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ABSTRACT

A seminar was held on the topic of case management, how it is being used, and whether case management is the answer to providing effective family-centered integrated services. The first panelist was Marie Weil, associate dean and professor at the University of North Carolina's School of Social Work. She claimed people do not need case management unless they have multiple needs. The next three panelists then turned to case management as practiced in specific program areas, starting with welfare reform. Chris Thomas, director of the Institute for Family Self-Sufficiency, American Public Welfare Association, described case management services as used in the Job Opportunities and Basic Skills (JOBS) program. Gary Silverstein, research associate, from the Institute for Family Self-Sufficiency, American Public Welfare Association claimed the question is not whether welfare-to-work programs should be implemented but how they should be designed to be most effective. The next panelist was Jim Callahan, the acting dean of Brandeis University's Heller School and the director of Heller's Policy Center on Aging who claimed that case management has been oversold as a needed service for the elderly. The final panelist, Gary De Carolis, deputy commissioner and director of the Child, Adolescent, and Family Unit of the Vermont State Department of Mental Health and Mental Retardation, described the current state of affairs in children's mental health in this country. He also discussed therapeutic case management. The three sections take up the definition, goals, and functions of case management; case management with different populations; and emerging issues in case management. (Contains an annotated list of 7 organizations, 52 references, and 4 charts.) (ABL)

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Service Integration and Coordination at the Family/Client Level

Part Three: Is Case Management the Answer?

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Service Integration and Coordination at the Family/Client Level

Part Three: Is Case Management the Answer?

April 24, 1992, Dirksen Senate Office Building, Rm. 138

Panelists: **Marie Weil**, associate professor, School of Social Work, University of North Carolina at Chapel Hill
Chris Thomas, director, and **Gary Silverstein**, research associate, The Institute for Family Self Sufficiency, American Public Welfare Association
James Callahan, director, Policy Center on Aging, Florence Heller School, Brandeis University
Gary De Carolis, deputy commissioner and director of the Child, Adolescent, and Family Unit, Vermont State Department of Mental Health and Mental Retardation

Moderator: **Theodora Ooms**, director, Family Impact Seminar

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Service Integration and Coordination at the Family/Client Level

Part Three: Is Case Management the Answer?

By

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(Revised December 1992)

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., Suite 901, Washington, D.C. 20036, 202/467-5114.

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SERVICE INTEGRATION AND COORDINATION AT THE FAMILY/CLIENT LEVEL

IS CASE MANAGEMENT THE ANSWER?

Highlights of the seminar meeting held on April 24, 1992, in the Dirksen Senate Office Building, Room 138. (A supplement to the Background Briefing Report.)

Theodora Ooms, moderator, opened FIS's third seminar in its series on integrated services by saying that everyone is promoting a "new breed" of agency staff called case managers as a solution or "magic wand" to help individuals and families get access to the services that they need. The purpose of this seminar is to clarify the term, case management, and how it is being used in different settings, and to discuss whether it really is the answer.

The first panelist was **Marie Weil**, associate dean and professor at the University of North Carolina's School of Social Work, and author of *Case Management in Human Service Practice*. Weil provided an overview of case management based on her 20 years of experience in different program settings.

Weil said that there is a value issue attached to the term, case management, which makes parents and others uncomfortable. In her view, people do not need case management unless they have multiple needs. People with a single need can be served by the system, but when people have multiple needs, and especially when they are further impacted by poverty, racism, or oppression, the need for case management arises. In other words, one needs to be vulnerable in some way, in a society where it is not acceptable to be vulnerable. "While many are trying to find an acceptable word, they are really struggling with this notion of vulnerability," she stated.

Weil added to her definition of case management (see page 4) that in practice, case managers are responsible for working with the client and family "in an ongoing relationship to develop an appropriate service plan to assure access to needed services, to monitor service delivery, to advocate for clients' needs, and to evaluate service outcomes."

In her view, case management has a dual focus, first at the level of direct family intervention, and second on service network intervention. In other words, although a case manager may advocate for a single family, s/he must do so in a way that advances the causes of all families in that class.

While many reduce case management to a cost-efficient, technical, brokering function, it in fact requires numerous, high-level skills, such as fiscal negotiation, group management, decisionmaking, and negotiation. Professionals must also learn to develop truly mutual partnerships with families. (She does not believe, for example, that therapeutic intervention requires a higher skill level than case management.)

Case management functions, roles, and models. Weil next reviewed the "Functions and Process of Case Management" (see Chart 1). She pointed out that monitoring service delivery is

often the most difficult function because workers often are not given credit for being able to evaluate competently the quality of service for their clients. She added that as the service system has become more complex, advocacy has become an increasingly important function.

In training case managers Weil utilizes a role chart as an excellent tool because it helps them to understand the complexity of the numerous roles which case managers must play (see Chart 2). She believes it is important that policy people also consider this complexity.

Weil then reviewed a diagram outlining case management system design choices and vulnerable populations served (see Chart 3). She highlighted the generalist service-broker model, the primary therapist model, and the interdisciplinary team model which is currently used in early intervention. The comprehensive service center model, unfortunately, has not been utilized much.

Weil stated that evaluation of services should be conducted at both client and program levels and, ideally, both case managers and researchers should be involved in this evaluation process.

At the policy level, all too often case management is assumed to fail because of case manager failure, when it will fail without administrative and policy support. System factors influencing the success of case management include administrative support, record-keeping systems that work and are user-friendly, an information management system which focuses on client outcomes, interagency agreements, availability of quality services, interprofessional collaborative relationships, and accurate and up-to-date information about services.

Case management, when properly implemented, is an integral component of a new philosophy of services in which categorical service provision has given way to a continuum of services ranging from prevention to securing treatment. A "child rescue" philosophy is now moving toward one in which services support and strengthen families.

Multiple service systems. Weil concluded by discussing a diagram which illustrated the many services, programs, and systems which need to work together on behalf of the client and family in the early intervention field (see Chart 4). As case managers in this field are becoming more successful in getting these systems to work together, they are helping to revolutionize service provision in other spheres as well.

Case management in welfare reform. The next three panelists then turned to case management as practiced in specific program areas, starting with welfare reform, an area in which federal policy has played a catalytic role. Ooms introduced the next panelists, **Chris Thomas**, director, and **Gary Silverstein**, research associate, from the Institute for Family Self-Sufficiency (IFSS), American Public Welfare Association.

Chris Thomas described case management services as used in the Job Opportunities and Basic Skills (JOBS) program, a program under the Family Support Act of 1988 which helps people get jobs so they can leave welfare. According to Thomas, many people believe that welfare-to-work programs are not succeeding because of the increases in the welfare rolls attributable to the recession. It is not clear that there has been a failure of service integration or case management. Indeed, Thomas indicated that there is evidence that the JOBS program is working and states are improving their services continuously. Thomas also drew a distinction between case management and (traditional) case work. Case workers, he said, address the client's presenting problem and provide the services of the case worker's agency, while case management includes the idea of empowering clients. In Denver, for example, a client advisory board was created which proposed that case managers help to run client-operated self-help groups.

JOBS implementation survey. The Institute for Family Self-Sufficiency conducted a nationwide survey of case management practices in the JOBS program in June of 1991 The Institute surveyed state agency administrators in all 50 states and a sample of local case managers

in 38 states and conducted focus group discussions (see summary on pages 13-14). The Institute plans to provide training for case managers in the future.

Thomas said that the IFSS survey found that some welfare mothers are able-bodied and ready to go to work, although they might be in crisis. On the other hand, some have numerous and sometimes severe problems, and are in need of many services. These problems might include illiteracy, mental retardation, a learning disability, substance abuse, medical problems, abuse as a child and/or spouse, mental illness, or an inability to speak English. When welfare mothers in focus groups were asked what enabled them to overcome such problems, they responded, "improved self-esteem," giving much of the credit to their case managers who listened, encouraged, and supported them.

Thomas emphasized that case management cannot work, however, without administrative support. He cited survey findings of extremely high caseloads (average 118), limited access to computers, and inadequate training. Thomas believes that training for case managers in the JOBS system will have applicability across systems because case management, by definition, involves linkage across systems.

Gary Silverstein summarized additional findings of the study. They found that in the majority of states, the state welfare office is the predominant provider of case management services to JOBS participants. Case managers have been recruited from the ranks of social service workers, income maintenance workers, and other staff outside the welfare office. In terms of qualifications, two-fifths of states do not require a college degree for JOBS case managers, just under half require a Bachelor of Arts or Science degree, only three require a Bachelor of Social Work, and none require a Master of Social Work or other graduate degree.

Although the majority of case management services to JOBS participants is provided by public welfare agencies, other organizations provide these services as well, implying that JOBS participants may be receiving case management services from multiple sources. These other organizations include the Job Training Partnership Act (JTPA/Private Industry Councils), adult basic education, mental health agencies, and community colleges.

State agencies surveyed indicated that they need training and technical assistance on assessment, evaluation methods, monitoring of participant progress, counseling, problem solving, and time management.

The question, Silverstein said, is not whether welfare-to-work programs should be implemented, but how they should be designed to be most effective. The answers to the following research questions, among others, he believed will help to determine how effective welfare-to-work programs should be designed:

- Is there a link between the professional and educational background of case management staff and program effectiveness?
- What can case managers do to ensure that their clients enroll in and successfully complete a JOBS component?
- What can state and local agencies do to facilitate communication between agencies and minimize duplication of case management activities?
- Is there a correlation between the amount of time that a case manager spends with a client and that client's success within the JOBS program?
- What can case managers do to manage high caseloads and target appropriate services to individual clients?
- What are the management information capabilities and needs of JOBS case managers?
- What performance standards and outcome measures should be adopted for the JOBS program?

Case management and the elderly. The next panelist was **Jim Callahan**, the acting dean of Brandeis University's Heller School and director of Heller's Policy Center on Aging. He had previously worked for 14 years in state government.

Callahan began by saying that many of the current proposals for integration of services and case management are not really providing a new answer to social problems but are ideas that have been around for a long time. His first job in social service, for example, was as a service coordinator, his first speech was on coordinated services for high school dropouts, and his first OEO proposal was for a neighborhood multi-service center.

In talking about case management in services for the elderly, he pointed out that the system for the aging is less closed than for other programs, i.e., the system is easier to get into for multiple services. He also clarified that when he is talking about case management he is not referring to managed care (i.e., insurance companies and others who use case managers as a primary method of controlling medical costs).

A number of studies in the field of aging have examined demonstrations involving case management in long-term care. People had high hopes that such services would decrease the use of institutional care, increase elders' functional status, and lower costs overall. The Channeling study, however, actually revealed increased total health care costs for these services (see page 17).

Case management is not a panacea. Callahan said he believed that case management has been oversold as a needed service for the elderly. He explained that it is not true that a large number of older persons are users of multiple services, and therefore potential users of case management. Research by the National Center for Health Statistics showed that only 7% of the elderly use two services, and only 2.7% use three or more.

In an open system, he added, many people can find services on their own. A Robert Wood Johnson study found that 95% of the seniors and 85% of the caregivers said they did not have a need for care planning, and 95% of seniors and 91% of caregivers did not have a need for a monitoring service. Only 5% of seniors and 8% of caregivers had a problem locating services. Callahan concluded that case management is best used selectively for a subgroup of the elderly population, yet there have been problems in appropriately targeting these services.

In the mid-70's, in anticipation of an increased demand in nursing home care by 1985, case management demonstration programs were developed in lieu of services. What resulted was a substantial expansion in home health care services, which in many ways reduced the need for case management.

Callahan recommended that before a case management system is implemented, one should examine the many services in existence already, and ask if it is really necessary. He suggested the following alternatives to expansion of case management services, particularly for the elderly:

- Provide more and better information. Most of the elderly and their families can make use of improved information, which likely will not come from additional service providers. (Rather, it will come from those who can develop the information technology.)
- Be sure that services are available first. Case management should not be provided in lieu of services.
- Redesign jobs to cut down on the multiplicity of workers.
- Give people money. If you give people the money, they will get what they need and drastically reduce the need to have someone else do this for them.

- Develop more closed, inclusive systems, such as health maintenance organizations, where services can be provided under one roof.

Case management and Wraparound services in children's mental health. The final panelist was **Gary De Carolis**, deputy commissioner and director of the Child, Adolescent, and Family Unit of the Vermont State Department of Mental Health and Mental Retardation.

Ooms explained that the case management systems that had been discussed thus far were designed to make present service systems work better. In Vermont, and increasingly in other state and local child mental health systems, case management was actually an integral part of a much reformed system, utilizing new and innovative approaches, such as "wraparound" services to be able to serve children in the community instead of placing them in institutions.

De Carolis first described the current state of affairs in children's mental health in this country. Many young people today are in out-of-state placements, and there is a tendency to overuse in-patient psychiatric care. In Maryland, for example, over 750 young people are in out-of-state placements, many of whom are in in-patient psychiatric care, at a cost of 236 million dollars. In Vermont, 26 young people are in out-of-state placements, down from 60 a couple of years ago, with the goal in the next few years being to end that practice completely.

Therapeutic case management. Therapeutic case managers (TCMs) are the lead people bringing these children back to Vermont. Their work involves collaboration with multiple systems, such as mental health, child welfare, education, and families. However, De Carolis stressed that without the infrastructure to ensure that multiple systems are working together, no one person can make a difference in the lives of these children.

De Carolis pointed out that children are different in relation to other populations in that they go to school, they live in communities, and they have families. These are but three basic systems that need to work together on behalf of young people, but usually there are many more. If these systems cannot work together to plan treatment strategies and to mesh services, even good case managers cannot help. In Vermont, in 1988 Act 264, legislation was enacted that mandated that various systems come together with families at local and state levels.

Therapeutic case managers have caseloads of only 4 to 12 children, which indicates the intense role that each plays with regards to any one child. The basic early function of therapeutic case management is to determine the needs of the young person, versus what the system can do for him or her. Each young person, he added, is unique, with a unique set of needs. "Wraparound" services, i.e., individualized services, are utilized to meet those needs (see page 19).

With a small caseload, TCMs are allowed the time to pull together individualized plans. TCMs are located in the community mental health center, and the majority of the children served have been from the child welfare system, and also those sent out of state from the education system. Trust in collaboration with these systems enables a case manager to serve the needs of a child.

According to De Carolis, to be successful TCMs must:

- be experienced (to make collaborations work);
- be savvy clinicians;
- know "what makes young people tick;"
- be team-builders;
- have a clinical consulting team to back them up;
- have flexible dollars that no categorical funding stream can provide;
- be "financial wizards" and Medicaid experts to arrive at funding strategies and financial plans (at the state level, the TCM coordinator takes these plans and maximizes the dollars available from state and federal sources, then brings these dollars down to the service level);

- be respected players within the community; and
- form an interagency treatment team made up of members of different systems, including family and extended family.

Screening of TCMs has been critical. With funding from the Robert Wood Johnson Foundation, there currently are seven TCMs in Vermont. The goal is to have at least one TCM in each of the 12 catchment areas in Vermont, and even more in the future. De Carolis hopes to get support from the state legislature for the time when the foundation money is exhausted, so early successes have been very important.

This program's target population thus far has been young people placed out of state. TCMs first visit these young people out of state to determine their needs before they bring them back to Vermont. The next group to be targeted will be children at risk of being placed out of state and those already out of their catchment areas. The third group which they eventually hope to reach will be those who are at risk of being taken from their families because of a mental health problem. Although TCMs are not currently targeting this population, there is a growing array of community-based services to stem that flow, including respite care for the family (the biggest need); intensive family-based services, bringing clinicians into the family; and crisis-outreach where clinicians meet the crisis where it is happening, rather than taking the child out of the family at the point of crisis, which is the worst time to move a child.

A case example. De Carolis gave the following example of a child and family who had received effective services from a TCM:

> A 15-year-old Vermont youth named "Emily" had been placed in residential treatment in Connecticut. Her mother was in jail because of a substance abuse problem and her father was in a VA hospital. Emily was scheduled to be discharged to her grandparents who lived in Vermont, but they were injured in a car accident and were unable to take her for the time being. They called the child welfare district office to get some assistance so that they could still care for Emily, and were subsequently referred to the community mental health center where a TCM was assigned. To assess Emily's needs, the TCM visited Emily in Connecticut, met with her grandparents and with Emily's mother, and formed an interagency treatment team. The early plan included respite care for the grandparents, and as the family grew stronger, some of Emily's aunts in Vermont became her respite care workers. Emily also was fully integrated into school; a lot of early work had been done with the new teacher, who at first was apprehensive. With flexible dollars, Emily---a sexual assault victim---was also enrolled in tae kwon do classes. Eventually Emily began voice lessons and got involved in the math club and yearbook at school. As Emily and her grandparents are now in the process of moving to Colorado as a family unit, the TCM is helping with all aspects of the transition and is putting together a subsidized adoption plan for the family.

De Carolis emphasized that the key is for TCMs to be flexible and to have flexible money. TCMs are also trained to be strength-based rather than focused on deficits. Therapeutic case management, according to De Carolis "is an exciting new way of doing business...to advocate and to empower." Vermont is now developing a comprehensive, community-based service system to keep young people in their communities and in their families so that they can go on to be productive members of society.

Points Made During the Discussion

- A participant from the Office of Management and Budget stated that it is apparent that there are many barriers to setting up a good case management program. He asked Weil and Callahan to comment further on the effective implementation of case management ideas.

Weil cited the need to look at training, as well as the need for administrative and legislative cooperation. Supportive administrative and policy-level people can make it possible for new ideas to work at the service delivery level. Regarding training, traditionally mental health, social service, and other professional workers have not been trained beyond their own disciplines' skills and basic responsibilities. In-service and pre-service training should teach people how to work together, to understand other people's work (across disciplines), and to work as a team to get to a common definition of what the client needs.

Callahan stated that in the elderly field, you get into "turf issues" over who should be providing these services, when case management itself is not necessarily the issue. He recommends first examining systems and programs, and considering how they can best work, what the goals are, how roles should be allocated, and how people can best work together.

- Another participant asked Callahan why there is such a tremendous proliferation of private geriatric case managers throughout the elderly field and corporate elder care if there is no real need to help people access this "open" system.

Callahan responded that in some cases, there is a real need, in some there is a perceived need, and in others, there is only a profit motive. In the experience of those programs, the many requests from caregivers is for information, with some actually needing help from the system, but this demand is not as big as people expect. If the availability of information and financing are improved, many people would like to manage the care themselves. Ooms also added that the Office of Technology Assessment has studied how to set up information networks specifically for families with Alzheimer's disease patients (see OTA).

Weil agreed that across populations, those who truly need case management should be targeted, being careful not to build more two-tier systems, as with health care. Even with better information, though, there are frail elderly who live alone, low-income elderly, and minority populations with special needs. Not all clients are in a position to access the system themselves. Intensive case management can serve to move people beyond the crisis point in order that they may manage their lives more effectively. Callahan commented that private geriatric case management tends not to address the most vulnerable groups.

- Another participant asked if there have been any case management programs where automated systems have told us what works.

Weil worked with Karen Smith Thiel (now of HHS's Office of Population Affairs) on the California Adolescent Family Life Evaluation, where a one-page sheet was utilized in each client file to track and monitor services for subsequent analysis. Data was collected on over 2,000 adolescent mothers. This study was state-supported. Weil added that to design good case management information systems, one must know what outcomes to look for, and then decide how to measure them. In the adolescent pregnancy and parenting programs, a set of 15 services were assessed, 5 or 6 of which most of the kids needed. From that information, they were able to determine which services most of the young people would need and the case managers were successful in linking the clients to these services (see Rounds, *et al.*, 1992). With the early intervention population, identifying the services would be much more difficult, because the population is so diverse (from low birthweight babies to children with spina bifida to children in poverty.)

- A participant from the National Center for Children and Poverty commented that she was concerned that there is a potential for creating super case managers, i.e., another bureaucratic layer which may interfere with the provision of services. She also asked panelists to address the adequacy of the service delivery system, and what kind of systems change is needed to make case management more effective.

De Carolis pointed out that case management is clearly not the answer by itself. In Vermont there are 65 different components within the system, including therapeutic case management as one of them. If there is no service capacity for that TCM to leverage in putting together the package of services a child needs, then no one person can do it. On the other hand, no matter how good a system is, someone needs to be skilled in finding the services. Both system factors, such as flexible dollars, and a creative treatment team have to be in place in order to achieve successful outcomes.

Weil believes that first, there must be decategorization. Second, case managers must document what clients need, but is not provided by the system, in order to then change the system. Third, there should be agreement about what a client needs so that roles and responsibilities can be negotiated.

- A Senate staffer concurred that case management is not a panacea and cited the overabundance of case management bills in the Senate recently. She wondered if Weil's assertion of targeting is in conflict with the idea of decategorization.

Ooms clarified that decategorization is really an issue at the federal---and possibly state---policymaking levels, while targeting should really occur at the service level. Weil agreed and reiterated that many do not need case management because they can get to the services themselves. Case management services should target multi-needs families, and the focus should be on meeting client/family needs rather than dividing up families and fitting them into different systems.

De Carolis stated that in Vermont, the monies for services are actually federal, from the National Institute of Mental Health (NIMH) to start the Child and Adolescent Service System Program (CASSP). The Department of Mental Health was required to be the lead agency to specifically address the needs of children and bring other agencies together. Other systems, such as child welfare and education, also needed help from mental health, so working together was very important. The difficulty, according to De Carolis, is in coordinating funding streams which have different time frames and procedures in a manner which is workable at local levels.

- A participant from the Maternal and Child Health Bureau asked about the concept of "self-sufficiency." If the goal of case management is to promote self-sufficiency, shouldn't a case manager's role be modified to become a care partner?

De Carolis clarified that therapeutic case managers in Vermont are care partners, but again there is an issue of labeling and terminology. Thomas added that the Family Support Act addresses clients as participants, and clients really seem to be treated as such. He supports the idea of "maximum intervention with minimum interference."

Weil pointed out that, regarding self-sufficiency, it is important to note that some vulnerable populations, such as people with severe disabilities, will never become fully self-sufficient and long-term care and maintenance service must also be offered.

- A participant from CASSP asked if it is feasible to put parents in charge of children's care (i.e., be their case managers) and to pay them, and whether this is already being done somewhere.

Weil responded that in the field of early intervention, in Iowa and Colorado, experienced parents have been paid as case managers for other families. It is important not to recreate the adversarial process which has occurred between professionals and parents of the mentally ill. Weil stated that she is not opposed to parents being care coordinators. Regardless of who is the case manager, she believes that there still needs to be public

responsibility for young people at risk. Professionals need to work with parents in an egalitarian, mutual problem-solving way, so that parents don't feel that the only way they can have some power in the system is to become a case manager.

- Another participant added that New York state and Pennsylvania are trying to find ways to pay parents within CASSP to be case managers. The reauthorization language for PL 99-457 (119-102) says that families can be paid as service coordinators, while the public agency still has the responsibility. Medicaid, however, will not permit parents to be case managers. Weil commented that not all parents have equal access to the opportunity to manage their children's care.

- Ooms asked the panelists to address the issue of case management standards, particularly the federal role, and whether or not it is possible and desirable to have uniform standards across such diverse populations and programs.

  Federal standards are to be developed by the Department of Health and Human Services for the JOBS program, according to Thomas. There is a question, though, as to how to define outcomes such as self-sufficiency. Performance standards, such as optimal caseload size and case manager qualifications, are a long way off. The federal government will be focusing mainly on participation in the program and compliance with regulations because there are no other definitive measures right now.

  Callahan suggested that standards might best be set at the level of programs, giving programs the flexibility to train people and to look at case manager qualifications and performance within that system, rather than setting standards at the federal level. A problem with setting standards at the federal level, for example, would be that there would be pressure to have standards which reflect the standards of particular professions.

  Weil thought the focus should be on best practices in each domain, perhaps setting standards at local levels. There are differences between rural and urban areas, for instance. There is incredible diversity among early intervention clients, not to mention the diversity among families. Standards should address quality of access, seeking those most in need of service. Federal standards, unfortunately, often encourage states to do only the minimum, rather than what actually needs to be done. The intent of the standards is critical.

SERVICE INTEGRATION AND COORDINATION AT THE FAMILY/CLIENT LEVEL

IS CASE MANAGEMENT THE ANSWER?

Background Briefing Report

INTRODUCTION

Case managers are becoming involved in the lives of a growing number of individuals and families with multiple problems and needs:

- A twenty year old, unmarried welfare mother with two children---one of whom has severe asthma---is enrolling in the state's JOBS program.
- An elderly woman's husband suffers from Alzheimer's disease and can no longer be left alone. She doesn't know where to turn for help.
- A young couple's second child, who spent his first year in hospital due to multiple severe handicaps, is now ready to be cared for at home if the family can get the services and supports they need.
- A farming family with five children are at their wits end and do not know how to manage their 14 year old son who is very aggressive and has had serious emotional and learning difficulties for years.
- A factory worker has just lost his job. His wife is expecting their third child, they can no longer pay their rent, and have no medical insurance.
- A homeless, alcoholic 28 year old; a mentally retarded 40 year old; a young mother with HIV; a 15 year old pregnant teenager; and many others.

Individuals and families in these kinds of circumstances need a range of services from different sources and for this reason, increasingly, they may have case managers assigned to help them. Who are these case managers? Why are they needed? What do they do? Are their services helpful and who pays for them? Why should policymakers be interested in case management?

Case management is increasingly viewed as the solution to the challenge of providing effective, efficient, coordinated service delivery to individuals and families such as these in both the public and the private sectors. The meaning of the term case management is elusive. It is used differently in various contexts. Case management is a complex and multi-faceted concept but, in essence, it is the case manager's job to identify individuals' and families' range of needs, help them get access to services, and ensure that these services are coordinated with one another.

From the client/families perspective, case managers can provide a number of benefits: information about what services they need, where to find them, how to use them, and how to pay for them. In addition, case managers may be able to help them establish clearer goals for themselves and

motivate them to make progress in various aspects of their lives, or at least to cope with their problems a little better.

Since the early eighties, federal financing for case management has become more widely available through Medicare and Medicaid waiver demonstration programs and through the broadening of covered services. Case management services are also being funded from other federal categorical programs and various state funding sources. A growing number of federal and state laws are now mandating case management and it is fast becoming a central feature of service delivery in a broad range of program fields. For example:

- **Welfare reform.** State welfare agencies are using case management as a strategic tool of the JOBS program to help implement the new emphasis of the 1988 welfare reform legislation on clients becoming self-sufficient.

- **Long-term care of the frail elderly.** Case management (sometimes called care management) has evolved to respond to two primary goals: controlling health care costs and helping frail or disabled elderly clients get improved access to the array of services they need to remain living in the community.

- **Early intervention services for children with special health care needs.** Case management, recently renamed "services coordination," is a mandated service in the 1986 P.L. 99-457 law requiring states to provide comprehensive, coordinated services for infants and toddlers with disabilities or at risk of developmental delay.

- In states striving to create **systems of care for severely emotionally disturbed children,** case management is integral to achieving the goals of comprehensive, individualized, community-based services.

- **Child welfare reform.** Several case management concepts---such as case plans and case reviews---are built into the child welfare system as a result of the 1980 reforms promoting permanency planning. Case management functions and methods are becoming a part of the repertoire of social workers/therapists implementing intensive, home-based services designed to avoid child placement or promote family reunification (see Ooms and Beck, 1990).

- **Other program fields.** Case management is also being widely used and promoted in many other program fields and with special populations, including: teenage pregnancy and parenting programs; two-generation early childhood and family support services; youth employment and training programs; services for the adult developmentally disabled and mentally ill; alcohol and drug abuse services for the homeless; and programs for families with a member who has tested HIV positive or has AID (see MDS Associates, April 1992).

- **Services integration and coordination initiatives.** Case management is fast becoming a central feature of both school-linked and community-based service integration initiatives and statewide systems reform initiatives, as discussed in the first two seminars in this series (see Ooms and Owen, September 1991 and December 1991). The National Center for Children in Poverty, as part of the National Center for Service Integration, is planning to conduct a special study of case management in service integration.

Case management is a key component of the New Futures Initiatives, funded by the Annie E. Casey Foundation, and other employment and training programs focusing on services for youth (see Center for Human Resources, 1989).

In this background briefing report we review the various ways case management is being used as the principal method of integrating and coordinating services at the service delivery level, both within and across several major categorical program areas and with varying population groups.

Focus of this report

Appropriately, many are bewildered by the growing use of a term which appears to mean so many things to so many people. Like many new policy buzzwords, case management is in danger of being oversimplified and misunderstood and is too often promoted as an all purpose panacea, guaranteed to patch over many of the flaws and gaps in the existing service systems. This background briefing report attempts to dispel some of the confusion by outlining the core concepts and issues that cut across these different program areas and various design models. We then provide a brief sketch of the ways case management is being carried out with different populations.

Existing publications provide rich, detailed descriptions of the evolving goals, designs, and operations of case management systems. In addition, there are a few well-designed demonstration studies, particularly on long-term care, that examine the questions of impact and cost effectiveness. National conferences are being held on the subject of case management and several organizations are developing case management training curricula to meet the growing demand for staff.

This report is the third in a series on family-centered integrated services. Building on themes in the first two seminars and briefing reports, we pose here three overarching questions as a framework for discussion:

- ***To what extent is case management the key to accomplishing the goals of providing coordinated, efficient, and effective services for families within the present service system?***

  Case management has evolved out of widespread concerns to improve the effectiveness and efficiency of a growing array of specialized health and social services. In this context, case management is perhaps viewed as a welcome new technology that will lubricate an outdated, rusty service industry and help it gradually adapt to new needs and trends.

  However, others believe these expectations of case management are unrealistic and that it can only serve as a temporary band-aid to patch over the basic structural flaws in the present categorical and fee-for-service system. Case management may be necessary but it cannot, by itself, accomplish the goal of individualized, effective comprehensive services for families. It may, however, need to be an integral component of a transformed system.

- ***To what extent are the lessons of case management and service coordination transferable from one service system to another? When the same funding streams are tapped to provide case management services to populations with very different needs and situations, does it make sense to impose uniform quality and performance standards?***

  There is mounting concern in the field to assure some basic standards for case management, yet there is virtually no research to base these standards on. Moreover, current experience suggests that the diverse functions and levels of intensity of service, both across and within particular population groups, makes it difficult and perhaps unwise to mandate uniform standards or qualifications.

- ***How can case managers be sure their activities supplement, rather than replace and supplant, clients and family caregivers' own efforts and responsibilities?***

Until recently, case management has been most highly developed in systems that served individual clients who were seen as literally, or conceptually, isolated from their natural context---their families---and who were generally considered to be incompetent to manage their own affairs. Case management, however, is now being adapted and introduced into program fields where the clients are capable and competent, and some which either target the whole family as the unit of service or provide family-centered services to individuals.

From this new family systems perspective the important issue becomes how case managers should relate to families, both as clients and ás partners in case management to individual clients.

PART I. DEFINITION, GOALS, AND FUNCTIONS OF CASE MANAGEMENT

(Sources: APWA, 1987 and 1992; Applebaum and McGinnis, 1992; Doolittle and Riccio, 1990; Kamerman and Kahn, 1989; Kane, 1985; NASW, 1992; Redford, 1992; Rounds, Weil, and Thiel, 1992; Steinberg and Carter, 1983; Weil, 1985; Weil and Karls and Associates, 1985)

Notes on terminology:

1. The use of the term case management is causing a good deal of controversy in some quarters. Elderly clients and many parents of children with disabilities strongly object to being considered "cases" who need to be "managed." Many professionals are also critical of the system-centric and paternalistic tone of the term. Thus, several alternative terms are being substituted in the program literature and in legislation, for example: care coordinator, care manager, family development specialist, service coordinator, etc. Although these alternative terms may in many ways be more appropriate, they are not yet widely known. Thus; in this report we shall regretfully continue to use the term case management.

2. The term case manager is increasingly being used in managed health care systems to denote the individual who serves solely in a gatekeeper function to review and determine eligibility for benefits and strives to protect against unnecessary or unnecessarily costly procedures or treatment. The individuals carrying out these tasks seldom meet with the client/family in person and do not have as their purpose the broad assessment of need or coordination of multiple services. Thus, for purposes of this report, we will not review the concept or operations of case management in managed care. (Indeed the growing use of the term case management in managed care may be a sufficient reason to change terminology and use the term service coordination.)

Definition and Goals

There are so many definitions and uses of case management that one author noted "case management is like a Rorschach test. An individual, agency, or community will project onto case management its own particular solution to the problems it faces" (Schwartz, *et al.*, 1982, p. 1006). Nevertheless, most definitions agree that case management is both a concept and a process: a broad concept setting out system goals and functions; and a service delivery method or process, a series of activities necessary to accomplish these goals. The primary goals usually identified are service coordination and program accountability. One of many definitions in the social work literature is:

> "case management is a set of logical steps and a process of interaction within a service network which assure that a client receives (an array of) needed services in a

supportive, effective, efficient, and cost-effective manner" (Weil and Karls, 1992, p. 2).

In the 1981 Omnibus Budget Reconciliation Act, Section 2176, which permitted states to apply for a waiver to cover home- and community-based services, case management was identified as a covered service and defined broadly as:

> "a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a defined person or group."

In one of the classic textbooks on the subject the authors point out that:

> "throughout its history case management has had dual sets of goals---one set related to service quality, effectiveness, and coordination and the other set related to goals of accountability and cost-effective use of resources. Given the perennial dilemma that the service needs of vulnerable populations inevitably exceed the program, staff, and funding resources of human service systems, the equitable allocation of resources as well as coordination of resources remain constant concerns for both direct service case managers and program administrators" (Weil and Karls, 1985, p. 2).

Twin goals. There is an inherent tension between the duality of the system-centered rationale for case management---based on concern for accountability and cost effectiveness---and the client-centered rationale---based on improving access, coordination, and quality of service. The system-centered rationale recognizes that resources are finite and, thus, case management serves as a rationing and priority setting function, especially in health care programs. Also, from the system/agency's perspective, case management provides a single point of accountability for services to vulnerable populations. The client-centered rationale focuses on helping clients navigate their way through the bewildering maze of services and overcoming the many complexities and barriers to using them effectively.

Some program uses of case management emphasize one of these two aspects of case management over the other. For example, initially, the major interest in use of case management in long-term care for the elderly focused on its promise to reduce or at least contain costs. Yet the cost containment and resource allocation function of case management has been much less emphasized in the implementation of case management in welfare reform and in children's services.

There is always a tension between the needs of the individual and the needs of the collectivity when resources are scarce (Callahan, 1989). The case management functions strive to integrate and balance these twin goals, but there is some debate in the field about whether in practice these two aspects of case management can, and should, be carried out by the same person or even the same agency.

Multiple historical roots

Historically, case management is the core role of professional social work. As pointed out by Weil and Karls (1985), the roots of case management and service coordination go back well over a hundred years to when both the early settlement houses and the Charity Organization Societies developed rudimentary attempts to document service needs, link and coordinate the provision of services, and advocate for improved services, especially for the immigrant populations. The Charity Organization Society, in particular, kept careful records and were concerned to use their

charitable funds judiciously, being highly sensitive to waste, fraud, and abuse. Social service registries and exchanges were the first formal mechanisms at service coordination.

Around the turn of the twentieth century social workers assessed individuals' and families' needs quite broadly and helped them access a variety of services in their environment. Social workers and public health nurses would often attend case conferences to review service plans for individuals or families who had multiple problems and service needs and they would make home visits. Much of the social work profession then turned in a different direction and became more clinical, and were generally trained in the theory and techniques of psychodynamic casework.

Nevertheless, in the fifties and sixties a few demonstration projects serving multi-problem, poor families assumed a more holistic approach and developed strategies for coordinating services---such as the Lower East Side Family Union's interagency agreements and service contracts. The home-based services movement, the precursor of intensive family preservation services, shifted the focus of social work with public agency clients back to include the client's interaction with systems in their environment and focused more sharply on specific goals and service plans.

The recent growth of interest in, and support for, case management among policymakers has several sources. Bailey (1989) pointed out that a major impetus was the **deinstitutionalization** movement that occurred in the 1970s in which hundreds of hospitals and residential facilities began returning mentally disabled and mentally ill clients to their local communities. These clients were deemed to be largely incapable of managing their own affairs and inevitably bewildered by confronting a fragmented service system. Case management evolved as a way of helping these clients live in the community.

In the area of children's social and health services, increased interest in service coordination arose from a heightened concern for accountability and new awareness of the inefficiencies, gaps, and unmet needs created by the present, uncoordinated system. In health especially, a driving motive was the escalating costs of health care. Moreover, the new availability of computerized technology served as a catalyst for placing a stronger emphasis on program accountability. These concerns began to be reflected in legislation which funded case management services and service integration projects in the seventies. The same trends have also led to the broader service integration and systems reform initiatives of the last few years, nearly all of which include case management as a central component.

What functions do case managers perform, what do they do?

An account of what case managers do generally begins with a review of the essential case management functions and related tasks and activities. There are numerous lists of functions to draw upon---the one used by the American Public Welfare Association (1992) identifies four, Weil (1985) outlines eight, and others list between 11 and 15.

We present here a revised and expanded version of the Weil categories of eight major case management functions (Weil, 1985, chapter 2). The activities are presented here in sequence but in practice they may overlap and be reiterative, or cut across the various stages. For example, although the initial assessment may be quite comprehensive, if the contact between the case manager and client continues beyond the assessment phase, new needs may come to light or current needs may fade away and the service plan will need to be readjusted. Since there is a small but growing trend to consider the family as the unit of service, we have included the family as well as the individual as the client.

1. Client/family identification and eligibility determination. The client or family may be referred by others, be self-referred, or, in the case of very vulnerable populations (e.g., the

homeless), the case manager may need to engage in outreach activities to contact the client/family. The referral may be voluntary or involuntary. The case manager at this stage will review general eligibility for the program and for specific services and benefits that may be needed and are provided by other agencies.

2. Comprehensive client/family needs assessment. Case management, as compared with the standard procedures of an intake/eligibility worker, implies going beyond the immediate presenting problem or medical diagnosis to carry out a more comprehensive, multi-dimensional assessment of current and potential functioning and of the social and environmental context in which the client/family lives.

A critical component of case management with vulnerable, dependent populations, which is not always stressed in the literature, is the need to assess the availability and willingness of the family or other members of an informal support system to meet some of the client/family's needs. Information for this assessment may come from the client/family, other caregivers in office-based interviews and home visits, and from other professionals and service agencies.

One of the basic assumptions underlying case management is that clients/families often cannot identify the range of services they need. They may not be aware that a service exists to remedy a particular problem, or of the relationship of one aspect of an individual's functioning or situation to another, or of the relationship of one family member's problem to others in the family. Importantly, they may initially deny the existence of a need or problem.

3. Development of a service plan. The first step is generally to decide upon a realistic set of goals and desired outcomes which will guide the service plan. The next activity involves matching the client/family's needs to resources, services, or benefits for which the client/family is eligible and which are known to be available in the community. It includes prioritizing needs and services for the individual and within the family.

In general, in preparing the plan the case manager needs to closely involve the client/family and anyone else whose cooperation will be needed to get it implemented. This may take some time and negotiation since everyone may not agree on its elements. When a client/family has already had contacts with other service providers, the service plan usually also needs to be developed in consultation with them. This may happen through holding a case conference for the professionals which may also include the client/family.

Sometimes, as in the Individualized Family Service Plan in P.L. 99-457, these service plans are written out with the goals, outcomes, and various roles and responsibilities of the agency, case manager, client/family, and other service providers all spelled out.

4. Implementation of the service plan: linkage and coordination. Case management implies going beyond simply referring the client/family to other services to include doing everything necessary to ensure that the client/family actually receives the service. If the services are all offered by the case manager's own agency, then the role of the case manager is to help facilitate the referrals, check that appointments are made and kept, and make sure the necessary information is transmitted to the other staff.

But if the services are provided by other institutions or agencies, the case manager may have to act as a broker, advocating for the needs of the client/family, negotiating issues of eligibility, and so forth. In addition, the case manager may have to help the client/family with practical details of transportation and schedule, taking care of other family responsibilities, etc.

If the service doesn't exist or a waiting period seems unacceptably long, the case manager may need to think of, and advocate for, some other creative ways of meeting these needs that go beyond the standard set of services.

5. Monitoring service delivery. When the case manager is not also an ongoing primary therapist/counselor, monitoring the service implementation process requires intermittent or regular planned follow up contacts with the client/family and often with other service providers. The case manager's concern at this stage is to assure that the planned services are being received, to check on the quality of the service and on the client/family's progress, and reassess the needs and adjust the service plan if needed. A number of forms and procedures have been developed (some computerized) that facilitate these complex tasks of case monitoring (see Nishimoto, *et al.*, 1991). In some agencies formal reassessments are required after certain time intervals. This may also be a time when disagreements emerge between client/family and other service providers which may need to be mediated.

In a complex service system in which any one individual or family may be receiving many services from many different sources, the case manager is the one person who should know at all times what the client's status is.

6. Advocacy/individualizing services. Clients may feel very vulnerable, powerless, and have their rights disregarded in a variety of ways by other service providers. This kind of experience may prevent their getting needed services and making progress. Thus, much, although by no means all, of the case management literature emphasizes the importance of the case manager being prepared to assume an advocacy role on behalf of the client/family with others within his/her own organization and with other service providers.

Sometimes the case manager will need to move into the role of advocating for the needs or rights of a class of clients, although usually this is done more effectively if the case manager alerts and enlists the efforts of a supervisor or administrator.

There is another aspect to advocacy. Sometimes the case manager finds out that the services the client/family needs simply don't exist. In this situation the case manager may need to pursue, within her/his own agency or with others in the community, creative ways of meeting these needs and try to identify flexible dollars to pay for these new services. This is the basic idea behind the "wraparound" services concept, which is being successfully applied in states and communities to meet the needs of children with serious emotional disturbances who simply do not "fit" into the existing pattern of traditional services (see p. 19). But it is a concept that is surely applicable to other populations as well.

7. Evaluation. A major function of case management is to collect, record, and file data about the client/family that documents service need, service provision, and the client/family's progress and outcomes. This will help in evaluations of the effectiveness of the case management service and is needed for the program/agency's overall accountability to its board, administrators, and funding sources. Increasingly, management information systems are being set up which, although costly and time consuming to put into place initially, do eventually facilitate the data collection and should make it easier to do ongoing monitoring.

Three additional components of case management that are not generally included in the lists but are clearly described in the literature are:

8. Termination/closing the case. Generally, the decision to terminate the client/family's relationship with the agency and case manager should be made jointly and not by default. This is an opportunity for all involved to review and evaluate the extent to which the service goals have been met. It is also a time for the case manager to help the client/family disengage from

dependency on the case manager and acknowledge the progress and new found independence or, alternatively, to help them move on to a new service relationship if their needs have changed (see Allen, 1990).

9. Building relationships/engaging and motivating the client/family. None of the functions above can be carried out mechanically. The case manager must build a strong, trusting relationship with the client/family even when he/she provides no direct treatment service but only brokers services provided by others (Allen, 1990). Building a good relationship is important right from the beginning to enable an accurate needs assessment and to develop a realistic service plan. (Clients will not share information with people they do not like and trust.) In addition, studies have shown that a good relationship is critical to ensuring compliance with medical regimes and to help clients develop the motivation to follow through and use services appropriately (see Allen, 1990).

Some case management systems strongly emphasize the need for the case manager to work to strengthen the capacities of the client/family to access and monitor services on their own, indeed to "empower" the client/family. This may include exploring with the extended family and social network whether they can be sources of support and assistance to the client/family. To help empower the client/family the case manager will function as teacher and coach. If successful, the case manager can then drop into the background, remaining available to the individual or family as a consultant as they perform their own case management.

10. Administrative support. All the functions and activities noted above need to be carried out by staff at the front lines of service delivery. But program administrators also should carry out a number of supportive activities that will make it possible for the front-line workers to do their job. At a minimum this may involve putting together community resource directories to facilitate information and referral services. In large agencies, administrators can hire specialist staff to whom the generalist case manager can turn for information and advice and assign clerical staff to help the case managers with their paperwork and data reporting (for example, see Hershey, 1991).

When the case manager's persuasion and attempts to collaborate across agencies fails to open doors, negotiated service agreements are essential. The case manager must have some clout, some authority and be given some assurance that the services his or her clients need from other agencies will be made available and provided expeditiously, that their clients will be treated equitably, and that information will be appropriately shared and followed up.

Thus, perhaps the most important of the administrator's tasks in a case management system is to negotiate formal or informal agreements with other service providers in the community that facilitate clients' access to these other services. These agreements will often include arrangements to pay for the service, to have reciprocal service exchanges, to develop referral and confidentiality procedures, and to pool sources of funding. Negotiating these agreements can often involve lengthy bargaining at high levels of the agencies but these agreements are critical to the success of any case management effort that involves coordinating services from different sources.

Scope of case management. This list of case management functions and activities is a comprehensive one. The extent to which any particular program or agency carries them all out, and with what level of intensity will vary enormously and depends on characteristics of both the agency/program and the individual/family.

Case management is applied in a wide variety of ways, in different settings, with different populations. Case managers have quite varied qualifications, caseloads that can range from 4-300, and interactions with their clients which can be limited to one or two office-based and telephone

contacts or can extend to intense, regular, in-person interviews in the clients' own homes over a period of months or years.

Agency characteristics that will shape the scope of case management efforts include the size of the case manager caseload---with caseloads of over 100, assessments may be somewhat cursory and monitoring quite limited. With caseloads of 25 or less much more intensive work is possible. In addition, it will depend on the breadth and scope of the program's goals. Some agencies will, for example, place more emphasis on a comprehensive assessment of needs, others will decide to assess only those factors that directly interfere with the employability plan or are directly related to addressing the health problem.

Client/family characteristics that determine the extensiveness of the case management include the complexity and intensity of service need, the availability of family and informal support, and the willingness and competence of the client/family to assume some of these functions themselves.

"Brokerage" versus "therapeutic" or "intensive" case management. One of the principal distinctions made in the literature is between the more administrative case management functions and the so-called clinical or treatment functions. Sometimes these are carried out by separate persons, units, or even agencies, but more often they are intermingled.

The administrative activities involve assessing the clients needs and benefits related to the program's eligibility, authorizing the payment and receipt of the benefits and services, and accounting for their provision and use. Sometimes this is all that a case manager does. And sometimes these services may be all that clients need.

The more clinical activities include assistance in finding and gaining access to services, seeing to their coordinated provision, monitoring need, and mobilizing informal sources of help. In these activities the case manager spends more time providing counseling and emotional support. In some agencies and programs these more clinical activities constitute most or all of a case manager's job. The case manager becomes, in effect, the primary therapist/social worker. In this situation case management is viewed as an extension of the clinician's role and the case manager is more often a qualified clinician---social worker, nurse, or psychologist.

Who carries out these case management functions?

There are three main design models agencies use to assign responsibility for these various case management functions, each has some advantages and disadvantages.

---**The single case manager** who implements all or most of the functions. Some agencies will have specialists available who can provide the generalist case manager with knowledge of particular resources or expertise.

---**Sequential case management** in which the responsibility for the client/family moves from one staff person to another as the client moves through the system. For example, the intake/eligibility worker may be a different person from the ongoing case manager.

---**Interdisciplinary team case management,** in which one member of the team is the leader and the others have specialties needed to serve the client. Client/family assessments and service plans are developed collectively by the team.

It is implicit in much of the professional literature that these case management functions are carried out by paid professionals or specially trained paraprofessionals. However, as noted, that assumes

that the client or family are unable or unwilling to perform any of these activities themselves. Although this may be true for a limited number of very disabled and isolated clients, it is clearly not true for the majority of clients needing case management services.

As several people have pointed out, while nearly all clients will need administrative and brokerage case management services, many will need or desire much less or no help with the so-called clinical and treatment activities. The client and/or his or her family or friends may be able to perform these activities or they simply may not get done.

Another alternative, which will be discussed below, is that the case manager and the client/family may decide to work out a way to share these clinical case management functions. The client/family may feel quite competent and willing to perform some activities, others they would prefer to delegate to the case manager. In these situations the case management functions are carried out in partnership with the client/family.

Tools and mechanisms to support and facilitate effective case management

Some of the organizational and financing mechanisms and tools currently being employed in service coordination initiatives can greatly facilitate case management. For example:

---**Home visits.** When administrators allow (or encourage) case managers to take the time to make home visits (and pay for their transportation), this can make it much easier to do the assessment of client and family needs and support systems and it will be more reliable. Home visits also often help build a more effective relationship with many vulnerable clients and their families.

---**Co-location of services**. While no guarantee, co-location of services can greatly facilitate coordination and access.

---**Case conferences,** which have a long history of use by social workers and public health nurses, can also be a very helpful tool to promote interdisciplinary and interagency communication and collaboration. Modern technology permits telephone conferencing which saves a great deal of time and expense.

---**Interagency service agreements** which specify resource sharing and facilitate referrals are, as already noted, a critical tool.

---**Flexible funding.** Interagency or intra-agency agreements to pool dollars in order to create more flexible funds that can be drawn upon by case managers to finance gaps in service or to create non-traditional services are an invaluable tool to promote more individualized service delivery.

---**Clinical Consulting Teams.** Clinical consulting teams are able to provide clinical support to Therapeutic Case Managers as they deal with unique situations of adolescents who are experiencing a severe emotional disturbance.

---**Management Information Systems.** Technology is now available to facilitate data collection and program evaluation and promote monitoring through tracking clients' service utilization and progress.

PART II. CASE MANAGEMENT WITH DIFFERENT POPULATIONS

CASE MANAGEMENT IN WELFARE REFORM

(Sources: APWA, 1986, 1987, and 1992; Bruner, 1991; Doolittle and Riccio, 1990; Golden, 1991; Gueron and Pauly, 1991; Hershey, 1991; Maximus, 1990; Smith, *et al.*, 1990; Smith, *et al.*, 1992)

Case management is a key component of the federal welfare reform initiative. What happens between the welfare client and the JOBS case manager is critical to the achievement of the goal of moving clients towards self-sufficiency.

The American Public Welfare Association (APWA), in its landmark report, *One Child in Four,* recommended case management as a key component of the organization's welfare reform proposals (1986). Prior to the passage of the Family Support Act in 1988, the main mission of the state welfare agencies was to determine eligibility, assure prompt payment of accurately determined benefits, and safeguard against abuse. The APWA report proposed that welfare agencies employ a new type of front-line employee---a case manager---in order to carry out their greatly expanded mission of promoting economic self-sufficiency. To do so they would need to help families assess their needs and resources, to implement and monitor the agency/client contract, and to coordinate the range of services that the clients may need to carry out the plan. In 1987 the APWA published the report of its task force on case management which outlined in some detail its vision for an effective case management system.

The provisions of the JOBS program as enacted in the 1988 Family Support Act gave states the option of instituting a case management system and receiving federal matching funds to finance these services. As stated in the legislation:

> "The State agency may assign a case manager to each participant and the participant's family. The case manager so assigned must be responsible for assisting the family to obtain any services which may be needed to assure effective participation in the program" (Title II, Part F, sec. 482. (b) (3)).

A recent APWA survey of state welfare agencies confirmed that all fifty states, two territories, and the District of Columbia had, in fact, chosen to use case management in the JOBS program. The federal regulations had declined to define case management or mandate any specific approach and the survey found there is considerable variation in the ways in which case management is being implemented by states in the JOBS program (see below). For example, in the law state agencies are permitted to contract out case management (and other) services, but none have chosen to do so. Although the Los Angeles County GAIN program, a precursor to JOBS, is using a private contractor, MAXIMUS, to provide case management services to their participants (see Maximus, 1990).

Lessons from the work/welfare demonstrations

(Sources: Doolittle and Riccio, 1990; Hershey, 1991)

Case management was an important feature of many of the state welfare/work initiatives of the late eighties such as the Massachusetts ET Choices program, the California GAIN program, and the three-site Teenage Parent Demonstration in New Jersey and Illinois. Since these programs were all carefully evaluated, there is a good deal of descriptive information available about the range of design models used and about the operational lessons learned to date in implementing case management in a welfare setting.

A process report of case management in the teenage parent demonstrations emphasized the importance of building a strong relationship with the client. The study found that the case manager's direct interaction with the teenage client was indeed a key factor in helping the participants be successful in the program (Hershey, 1991). The case managers spent a good deal of effort motivating and encouraging the teen clients, helping them deal with personal crises, monitoring their attendance in program activities, and enforcing the rules that required active participation. This study also reported on several ways in which program managers can be helpful to the front-line case manager.

However, a 1990 review of the ET and GAIN experiences suggests that little is still known about the implications of the various case management design models on client participation in program activities or ultimate program impacts on employment, earnings, welfare receipt, and other outcomes. There was no evidence to shed light on whether programs would be better off serving more clients with less intensive case management or fewer clients with more intensive case management. A more recent report, however, finds some evidence to suggest that targeting intensive services to the clients who are the least job-ready is a good idea (Gueron and Pauly, 1991).

Thus far it has been difficult to measure the impact of case management in welfare-to-work programs in quantitative terms. A study in Riverside, CA is planned to assess the outcomes of intensive case management by comparing two groups of welfare recipients, one group assigned to case managers with normal case loads, and the other group to case managers with half the normal caseload (Gueron and Pauly, 1991).

American Public Welfare Association (APWA) survey of states' implementation of case management
(Source: APWA, 1992)

In 1991, the APWA Institute on Family Self Sufficiency conducted a nationwide survey of case management practices in the JOBS program. Data was obtained from questionnaires completed by state agency administrators from all 50 states and by 201 local case managers in 38 states. These findings were supplemented by focus group discussions with JOBS case managers and JOBS participants in five sites.

Almost all the state agency administrators rated case management as an effective way of serving JOBS participants, but they also indicated that their effectiveness was reduced by budgetary constraints (which were beginning to be quite serious), the heavy reporting requirements, and high caseloads.

Selected findings of this survey are as follows:

- States conduct the initial client and family assessments and develop employability plans in various ways, using forms of varying length and detail. Some states appear to conduct more comprehensive assessments when a participant is not making satisfactory progress. It is unclear how the case managers are assessing the circumstances of family members or the clients' health status or substance use.

- There does not appear to be much targeting of case management. Most states (41) are assigning case managers to all JOBS participants rather than only to special population groups.

- Case managers reported considerable difficulty in helping participants find affordable child care and in focus group discussions reported that participants are frequently exempted from

participation due to lack of child care, transportation, or other services, but the survey did not collect the data to confirm this impression.

- Three-quarters of the respondents viewed counseling as a key function of case managers, especially for those clients who have serious problems that interfere with employability or participation in the JOBS program, such as illness, disability, and substance abuse.

- Case managers reported spending an average of 39% of their time on participant-related paperwork. This finding is especially troublesome in light of the study of the New Jersey REACH program's case management which reported that the more time case managers spent in direct contact with participants (and the lower their caseloads) the more successful the clients were in employment-directed activities (New Jersey, 1991).

- Nearly 40% of states are assigning these new case management functions to social service workers, 33% to income maintenance (eligibility) workers, and 24% to employment counselors. Although most of these staff are given specific, additional training, the survey didn't ask for information about how extensive this was. Notably, many traditional areas of case management knowledge and skill were reported as typically not covered (e.g., counseling, family development, cultural diversity, or relations with other service providers). Average full-time case management salaries are below $25,000 in 66% of the states. In only 11% of the states were they higher than $30,000.

- Most states do not establish standards for maximum caseloads. Caseloads reported by case managers in the survey ranged from 10-500 with the average being 118.

- Respondents reported that the most coordination activity occurred with adult employment services, there was less with other types of community agencies. One repeated finding from the focus group discussions was that many of the JOBS participants have multiple case managers based in other agencies who do not communicate with each other and duplicate each others activities.

Overall, state and local respondents appear to highly value the new case management function, but serious resource constraints are frustrating implementation of case management and impeding its effectiveness.

Family-centered case management in welfare reform
(Sources: Allen, 1990; Bruner, 1990; Golden, 1992; Smith, Blank, and Bond, 1990; Smith, Blank, and Collins 1992)

The Family Support Act (FSA) opened a window for the use of family-centered approaches to the problems of welfare dependency. Provisions of the JOBS program require a comprehensive review, including family assessment and mobilization of supportive services (including child care) needed to remove barriers to the parents' employment. The Act states:

> "The State agency must make an initial assessment of the educational, child care, and other supportive service needs as well as the skills, prior work experience, and employability of each participant in the program including a review of the family circumstances. The agency may also review the needs of any child of the participant..." (P.L. 100-485, Title II, Part F, Sec. 482 (b)(1)(A)).

It was clearly the intent of the framers of the law that AFDC children would indirectly benefit from this legislation through the gains made by their parents. However, many people, in particular the Foundation for Child Development, have emphasized the potential of FSA programs to improve

the life chances of disadvantaged children by directly addressing their health and educational needs as well as the vocational needs of their parents. Case management services have been identified as one of the components of the JOBS program which could be of direct benefit to children, since case managers could potentially link children and families to a range of needed services and help to coordinate them.

The Foundation for Child Development has funded research, a conference, and several demonstration programs that focus on providing services to both generations on welfare. In an effort to identify lessons for other jurisdictions as they implement the Family Support Act, two Foundation-funded publications report on studies of the basic elements and operations of 15 community-based, two-generation programs operated by or in conjunction with welfare departments that successfully serve children and their parents (see Golden, 1992; and Smith, Blank, and Collins, 1992).

Golden's study provides an in-depth picture of some of the pressures, traditions, practices, and attitudes prevailing in welfare agencies that make it very difficult for case management staff to shift their mission to a family-centered one. In addition, it reported on the widespread isolation, mistrust, and multiple needs of many welfare families that have to be overcome in order to achieve the personal and program goals for themselves and their children. The solutions that the seven sites she examined devised to overcome these barriers and challenges were quite varied but shared certain common elements. Among those most relevant to welfare case managers were:

- Development of a clear, coherent mission to serve the family unit that emphasized serving families rather than just processing them.
- Creating effective collaborations with other agencies.
- Intensive personal work with families conducted by a case manager (or similar type of staff), with a relatively low caseload, and often involving outreach into the families homes. (Five of the seven sites had caseloads of between 20-40 families.)
- Careful recruitment of staff and strong administrative support for them.

The report makes a number of recommendations related to strengthening the ability of case management in welfare agencies to more effectively serve the family unit. One of the most salient perhaps is that welfare agencies should consider targeting a particular group of families for intensive case management services that would address the needs of all the members of the family, not simply those needs that appear to be direct barriers to maternal employment.

The second report, *Pathways to Self Sufficiency for Two Generations,* draws on the findings of the study of eight two-generation welfare-to-work programs to identify basic elements of a family-focused program that the authors believe could be incorporated more widely in the JOBS program (Smith, Blank, and Collins, 1992). Among these, three are especially relevant to the issue of coordination.

- **Assessment of child and family needs.** Exemplary JOBS' assessment protocols include the following topics in their initial assessment: family circumstances, parenting strengths and concerns, parents' and children's utilization of health care, and parents' preferences for child care and health care.
- **Knowledge of, and referral to, the Early Periodic Screening Diagnosis and Testing program (EPSDT).** JOBS program case managers could cooperate with the EPSDT outreach activities to inform their participants about EPSDT screening and treatment

and encourage them to seek these health prevention services for their children (which are paid for under Medicaid).

- **Case management in JOBS.** The exemplary two-generation programs provided examples of the importance of clearly allocating roles and responsibilities when clients have more than one case manager assigned to them (e.g., Head Start, JOBS, and family support program case managers). In addition, the report suggests that family circumstances and child needs should be included as criteria for any targeted case management, not solely the degree of job readiness.

CASE MANAGEMENT IN LONG-TERM CARE FOR THE ELDERLY

(Sources: Applebaum and McGinnis, 1992; Callahan, 1989; Downing, 1985; Health Systems Research, Inc., 1991; Kane, 1985; Kemper, 1990; OTA, 1990 and 1991; Phillips, Kemper, and Applebaum, 1988; Pillemer, MacAdam, and Wolf, 1989; Spitz, 1987; Steinberg and Carter, 1983; Weil and Karls, 1985)

Case management is now widely accepted as an essential component of all long-term care systems for the elderly. Case management is included as a key feature of virtually all recent long-term care proposals. Of six major proposals introduced between 1988 and 1991, three of these provide coverage for disabled children as well as for the elderly (Health Systems Research, Inc., 1991).

The growth of public funding of case management services in community-based care of the elderly has been largely a response to escalating costs of health care, financed largely through the Medicare (Title XVIII) and Medicaid programs (Title IX), both of which were biased in favor of institutional services. Since 1972, the federal government has been attempting to control health care costs and has taken a series of steps to find ways to finance community-based, long-term care, which it was hoped might lower overall costs. As these developments have proceeded, the guiding concerns of policymakers have been:

- To control costs by assuring that funding for any expanded community-based services should either be substituting it for more expensive, institutional care or should be meeting a hitherto unmet need. A dominant fear was that these expanded home-care services would be simply replacing services presently performed informally, without reimbursement, by family members or others, and that elderly not at risk for institutionalization would "come out of the woodwork" to seek services and greatly escalate levels of demand.

- How to maintain and assure quality when services are provided largely unsupervised in the home.

Not all case management expansion in aging services has arisen from the desire to control costs. The state Area Offices on Aging, adopting an advocacy stance, provide case management services in order to help the frail elderly get access to more services.

Expansion of public funding for community-based care and case management

The 1972 amendments to Medicare, known as Section 222 waivers, permitted states to fund demonstrations to assess the cost effectiveness of alternatives to institutional care. Similarly, community care demonstrations have been funded through Section 1115 waivers under the Medicaid program. The Triage program in Connecticut, the Access program in Rochester, NY, the On Lok Senior Health Services in San Francisco's Chinatown, and the Alternative Health Services project in Georgia were all well known demonstration programs funded under these various

waivers. Case management has been a strong feature of most of these demonstrations. Drawing on these experiences, in 1980 a very ambitious ten-site National Long Term Care Channeling Demonstration was launched by the Health Care Financing Administration, and again case management was an integral component.

In 1981, under the Omnibus Budget Reconciliation Act, Medicaid Section 2176 waivers permitted all states to offer care in the community to persons who would otherwise need nursing home care, provided the costs of care were no more than 75% of the predicted nursing home costs and that a management plan was followed. Again, case management was a feature of nearly all the state plans. In 1983, the introduction of the DRG reimbursement system placed an emphasis on the case management services provided by a hospital discharge worker. Finally, in 1985, under the Consolidated Omnibus Budget Reconciliation Act (COBRA), states were now permitted to provide case management as an optional Medicaid service without seeking a federal waiver.

As compared with some case management systems, it is important to note that when case managers operate within a Medicaid or Medicare funded system they have a high degree of control over what services the eligible clients may receive.

Lessons of the Channeling and other home-care demonstrations. What has been learned from these demonstrations about the value of case management services in the care of the elderly? Several reviews of the results of these demonstrations have found no convincing evidence that these case management-oriented programs reduce hospital or nursing home stays, lower costs, or improve overall health or functioning.

The Channeling study results were especially significant and disappointed those who had hoped for cost savings from expanded home care services. The Channeling study, using a randomized experimental design, was a national test of expanded public financing of home care conducted from 1982-1985 and funded by the Health Care Financing Administration. The project sought to test the hypothesis that by substituting case-managed care at home for care in a nursing home, there would be cost savings and the quality of life of elderly clients would be improved.

The major finding, which received much attention, was that contrary to its original intent Channeling increased total health care costs. This was largely a failure of targeting. (As with the evaluations of family preservation programs in the child welfare field, it turned out to be very difficult to limit the participation in the study to those who were at imminent risk of nursing home placement.) The population served was indeed very frail, but in most cases it became apparent they would not have entered nursing homes even without the expanded home care services. Most other rigorously designed studies of the same question have had similar results (see Kemper, 1990).

However, other less well known findings from the Channeling study were also important and were somewhat more positive. The woodworking fear (substitution effect) turned out to be not well founded. There were no substantial reductions in informal care giving as a result of expanding funding for home-based services. Channeling clearly resulted in providing increased levels of services that reduced unmet needs and also increased client and family satisfaction with services. Moreover, although more services were received overall, Channeling case managers were able to negotiate decreased expenditures on some personal care and supportive services by substituting lower cost services for higher cost services. And case managers were found to be central to the quality assurance process, both through their regular monitoring activities and their leverage to improve provider performance through shifting clients to other providers.

The Channeling demonstration also was able to document the relatively high costs of case management services. The initial enrollment/assessment costs were an estimated $346 per client and ongoing costs averaged about $86 per month. These findings about the costs of case

management services in long-term care raise the question about whether everyone needing services should be subject to the full case management treatment. Kemper suggests that it might be more efficient to find a simple way of screening into the program only those prospective clients whose conditions were chronic and complex and who would need case management services over a long period.

The Channeling demonstration, as Kemper points out, was designed to answer the question about whether to expand home care benefits. This question appears to have been decided in the policy arena in favor of expansion. The question now shifts to the largely unexamined question of how best to administer home care benefits and whether case management systems or some other system is to be preferred.

Another question, raised by Callahan, is whether a large consumer demand for case management services really exists among the frail elderly or whether it is not driven more by the needs of providers themselves (Callahan, 1989). The widespread assumption that large numbers of the elderly need multiple services, and hence the services of case management to access and coordinate them, does not have much solid evidence to support it, Callahan maintains. Moreover, consumer surveys of the elderly using home health care services reveal that the vast majority said they had no need for care planning or monitoring. On the other hand, surveys of family caregivers of Alzheimer's disease patients reported that they have a great deal of difficulty locating services and becoming linked with appropriate services and very much needed assistance in doing so (OTA, 1990).

It seems likely then that case management services for the chronically ill, frail, or disabled elderly need to be targeted carefully on special groups and that not all elderly clients and their caregivers will need the full range of services that are needed by a few.

INDIVIDUALIZED SERVICES FOR FAMILIES WHOSE CHILDREN HAVE SEVERE EMOTIONAL DISTURBANCES

(Sources: Behar, 1986 and 1991; Burchard and Clarke, 1990; Franz, 1990; Santarcangelo, 1990; Stroul and Friedman, 1986; Van Den Berg, in press)

In the early eighties, national and state leadership in the child mental health, child welfare, and juvenile justice systems became alarmed at the rising numbers of seriously troubled children who were being placed in foster homes, psychiatric hospitals, and institutions, often outside the state. Since then there has been a growing awareness of these children's complex needs and the extraordinary challenges and demands they place on the traditional service system. A new consensus is emerging that families whose children have severe emotional disturbance require intensive case management within a framework of highly individualized services.

Seriously emotionally disturbed (SED) children have difficulties in many spheres of life: in school, at home, in the community, and with their peers. Traditional psychiatric services available in the community---once a week outpatient clinic visits or inpatient hospitalization---are simply not adequate. Typically, especially as they grow older, SED youths' behavior becomes very difficult for people to cope with. As a result, they are frequently declared misfits, ineligible for traditional services, bounced around from program to program, they may get into trouble with the law, and are eventually placed in out-of-home care. Although their numbers are relatively small, the costs of serving them are immense (up to $70,000 or more per year). The lack of appropriate services, the failure of the service systems to coordinate their efforts, and the attitude of many professions that these children are essentially "untreatable" is deplored.

A new vision for how to best meet the needs of these children and their families began to be articulated by a group of mental health professionals. This vision required that treatment dollars be redirected into creating a continuum of community-based, coordinated services. The model proposed that communities should develop **systems of care** within mental health, education, social, health, and recreation, that would provide a wide range of services that would be child- and family-centered and coordinated (Stroul and Friedman, 1986). The continuum's components ranged from intensive in-home services and outpatient and day treatment services to psychiatric hospitalization.

In 1984, the Child and Adolescent Service System Program (CASSP), situated in the National Institute of Mental Health, began a small program of federal grants to states to help catalyze the development of statewide systems of care based on what became known as the CASSP model. A few states and localities have made remarkable progress and are successfully returning numbers of SED children to their communities and, as program evaluations suggest, at considerable cost savings.

One such state was North Carolina which, under the stimulus of a court order directing the state to place these difficult children in less restrictive settings, mounted a multi-agency effort under the leadership of Lenore Behar, director of the children's mental health division, to improve the service system. Over five years they were able to create the initial elements of an integrated system of community-based services for seriously emotionally, mentally, and neurologically handicapped children and adolescents who were also violent and assaultive, proving that many of these children could be served in their communities and helped to function better. The program, known as the Willie M. program, became a national model and in 1990 received a major four-year demonstration grant from the R.W. Johnson Foundation.

Case management in CASSP. Case managers are a critical component of the CASSP model, as they are responsible for developing the individualized treatment plan for each child, for continued coordination of the services, and for advocacy for the child and family. Typically, case managers in North Carolina are responsible for only 12-15 clients and provide much direct counseling and therapy themselves. While there have been some studies of case management services for adults with severe and persistent mental illness, no studies have yet been conducted to shed light on the design and effectiveness of case management in children's mental health. In 1991, Lenore Behar, in collaboration with the University of North Carolina at Chapel Hill and Duke University, received a three-year research grant to conduct a study of the effectiveness of case management services in the demonstration in two northern counties. The study will be designed as a randomized clinical trial with an experimental group of SED children assigned to a multi-agency treatment team with individual case management and a control group assigned to a multi-agency team without a case manager.

Wraparound, individualized services. The success of the Willie M. program and the Alaska Youth Initiative led to a further elaboration of the philosophy and approach of the systems of care model through introducing the concept of wraparound, individualized services. It was pointed out that even if all the service components of a continuum of care were in place, some of these children would still fall between the cracks.

"Wraparound" is an especially vivid metaphor which is rapidly assuming a variety of meanings. Its first mention in the literature was in a 1986 article in *Children Today,* authored by Behar. In this article she outlines the rationale for setting aside flexible dollars to pay for non-traditional services which are often needed to help troubled youth remain in the community and participate in traditional service programs (Behar, 1986). As an example, wraparound funds could be used to pay for respite care services to give stressed parents a break, for judo lessons and exercise classes to help adolescents let off steam and achieve some successes, and to pay an older adolescent to be a friend to a troubled youngster and teach him how to repair his relations with his peers. In short,

these flexible funds were needed to support imaginative, creative ways to meet youngsters' needs that were not being met by traditional services.

John Van Der Berg, who directed the successful Alaska Youth Initiative (AYI), and his colleagues have emphasized the fundamental philosophical shift involved in starting with the assumption of individualized care (see Burchard and Clarke, 1990; and Van Der Berg, in press). In contrast to the usual case management approach of trying to "fit" a troubled child and family needs into existing services, the individualized care philosophy begins by asking: What does this child/youth and family need to function better? The service system makes an unconditional commitment to assuming responsibility for the child: no matter how disturbed the child and impossible his/her behavior, the child will not be passed around to other agencies. It then proceeds to create a network of services for the child and family through combining traditional services with creating new "wraparound" interventions. This philosophy was especially effective in Alaska where few traditional services existed.

Therapeutic case management in Vermont's CASSP system of care. Case management remains an integral part of most individualized care planning and implementation for the SED population, but it assumes a much more proactive and creative role than is described in most of the case management literature. Historically, case management services have been the responsibility of the particular agency or program in which an individual is being served. However, in the CASSP programs case management becomes a cross system function and case managers have to function much more as coordinators of an interagency team.

In Vermont, following up on the establishment of its System of Care Plan for (SED) Children and Adolescents, a 1989 special task force carefully spelled out the mission, functions, and operations of the therapeutic case manager.

> "The purpose of therapeutic case management (TCM) is to use natural supports in the community and/or organize services provided by agencies...to act as the person accountable for coordinating and ensuring appropriate and timely services...and responsible for brokering services for individuals, and advocating on the child's behalf across service systems" (Santarcangelo, 1990).

The therapeutic case manager acts as part of an interdisciplinary team which collectively conducts a broad, ecologically based assessment of the child in its family, school, and neighborhood setting.

The TCM carries out all the usual functions of a case manager, but two functions have been added: (i) "The TCM and treatment team brainstorm interventions and creative strategies to overcome obstacles, developing individualized services when none are available through existing programs." In addition, (ii) the case manager and team are responsible for ongoing education and public awareness efforts directed towards parents and members of the community relating to the integration of SED children into the community.

Two additional points in this task force report are distinctive. First, acknowledging that resources did not yet permit providing TCM services to all SED children, four target groups were designated to be phased in for services in order of priority:

---children and adolescents already in out-of-state placement;
---children and adolescents at risk of, or already in, out-of-home placements within the state;
---those requiring multiple services referred to the Local Interagency Team/State Interagency Team to resolve problems;
---and finally, all other SED children requiring multiple services.

Second, different phases of TCM were noted as requiring different levels of intensity of services as the child and family moved through them. The initial intake and treatment planning phases are usually the most intensive, services then usually stabilize somewhat as community supports learn to be more effective. After a maintenance phase, the child and family will finally make the transition into an inactive status. (Passage through these phases will normally take at least 2-3 years.) The TCM's caseload size would thus depend on how many children were in the intensive phases and could range from a caseload of 5 to no more than 12 children and their families.

These services are funded from a variety of sources. In addition to state dollars, every possible federal funding stream is utilized. The guiding philosophy behind the funding of therapeutic case management is to allow flexibility of dollars so that services can be developed and implemented to meet the child's unique situation. Also, maximizing federal receipts allows a state like Vermont to serve more children with its limited general fund dollars. Typical blending strategies involve mental health, child welfare, education, federal dollars, and social support.

FAMILY-CENTERED SERVICE COORDINATION FOR CHILDREN WITH DISABILITIES

(Sources: Anderson, *et al.*, 1991; Bailey, 1989; Hausslein, *et al.*; 1992; McGonigel, *et al.*, 1991; Zipper, *et al.*, 1991)

Families whose infants and young children are medically fragile, developmentally delayed, or physically impaired are another population with multiple needs for services. Over the years parents of these children have become powerful advocates for services for their children and have helped to ensure the success of landmark federal legislation, Part H of P.L. 99-457, the Education of the Handicapped Amendments Act of 1986. The law mandated states to develop comprehensive, coordinated service systems to meet the needs of infants and toddlers with disabilities and their families. Case management was included as one of the mandated services. Families may not be charged for these services. The case manager was required to provide a single communication point for the family in all their various dealings with other professionals (see description of P.L. 99-457 in Ooms and Herendeen, 1990).

The explicit family-centered focus of the legislation, its acute sensitivity to parent rights, and the inclusion of parents in a variety of active, participatory roles has resulted in a model of family-centered case management that is unique in law, and probably also in practice. The regulations underscored the intent of the law:

> "The Secretary recognizes that parents (1) must be actively involved in making sure that their eligible children and other family members receive all of the services and protections that they are entitled to under this part, and (2) are major decisionmakers in deciding the extent to which they will participate in, and receive services under, this program" (54 Federal Register, 26331, 1989).

The term case management was clearly too paternalistic for this population and was heavily resisted. The 1991 reauthorization of the Part H program under the Individuals with Disabilities Education Act (IDEA), P.L. 102-99 made a symbolic but important change in the terms used in the legislation. Throughout the law, "service coordination" and "service coordinator" were substituted for "case management" and "case manager." Service coordinators were to continue to carry out all the functions of case management spelled out in the 1986 law.

Several provisions in the original law and some new provisions in its recent re-authorization clarify the active, collaborative role of parents in the implementation of service coordination functions and tasks, as summarized recently by Hausslein and colleagues in an article in *Zero to Three* (1992):

- Parents (and other members of the family if they choose) are to be involved in the assessment of their child's needs and must participate with members of the multi-disciplinary team in developing the written Individualized Family Services Plan (IFSP).

- Parents are to make all final decisions about the assessment and which services are to be provided.

- Parents are free to reject the services of the service coordinator without jeopardizing their receipt of any of the other services.

- The qualifications required for service coordinators are now written in a way that emphasizes knowledge and experience so that parents may become the official, paid service coordinators for their own children. (This had been precluded in the 1986 law.)

- Parents may become service coordinators for other children and their families. The Part H program funds several parent training centers which are being used as a resource for training parents to be advocates, be involved at policy levels, and assume some or all service coordination functions.

- Parents may be involved as teachers in the training of other professionals and other parents to be service coordinators.

Results of a telephone survey conducted in the fall of 1990 revealed that most states were still in the planning stages for many aspects of the implementation of the case management provisions. Half of the states reported that they planned to use Medicaid dollars to help finance the service coordination activities. Other sources of financing they would use are state funds and Part H funds (Anderson, *et al.*, 1991).

Another more recent study of implementation of the service coordination activities to date reviewed 26 states' fourth year application plans for Part H funding and other memoranda and talked with many parents. The emphasis in several of the state plans was on creating the elements to promote the partnership model of case management/service coordination and a few states wrote that the goal should be to enable the parents to independently assume as much of this role as possible (Hausslein, *et al.*, 1992). Several states were actively involved in developing job descriptions that would put parents on a par with other professionals in applying for the paid positions of service coordinator and planned to involve parents in their training and teach parents how to collaborate with service coordinators. Finally, parents reported a good deal of enthusiasm for participating in the policymaking bodies, the Interagency Coordinating Councils, most especially when they were developing plans for the IFSP and service coordination activities and felt that their voices were being heard.

FAMILY-FOCUSED CASE MANAGEMENT IN THE COMPREHENSIVE CHILD DEVELOPMENT PROGRAM

(Sources: Hubbell, *et al.*, 1991)

The Comprehensive Child Development Program (CCDP) is a legislatively mandated, 5-year, comprehensive family support demonstration program that is designed to address the needs of low-income children and their families. It provides the clearest conceptualization to date of a national

program designed to provide multiple, coordinated services to the family unit through the services of a case manager.

The CCDP program seeks to assist children in reaching their full potential and enable parents to achieve economic and social self-sufficiency. Twenty-two projects were funded in 1989 and two additional projects were funded in 1990.

CCDP uses a family-focused case management approach to coordinate a very wide range of services that are either provided by the program itself or by agencies in the community through a series of cooperative written agreements, contracts, or by referral.

The CCDP's first Annual Report, published in December 1991, discusses how CCDP was conceptualized, describes the programs and families served during the start-up phase, and provides some initial implementation findings. (Grantees are using a state of the art management information system and an impact evaluation is being conducted by ABT Associates.)

The report states that the use of the family-focused case management was a critical component of the project's design and implementation. It is interesting that the case managers are given a variety of titles including home visitor, family advocate, family consultant, family service provider, and family development specialist. They provide nearly all the traditional administrative and clinical case management functions. In addition, case managers may provide home-based early childhood and parent education activities, although sometimes these are carried out by another member of the staff.

Although the titles and exact job descriptions of these case managers vary from one project to another, all used a **family needs assessment** and developed a **family service plan.** The case management function in CCDP is infused with family support principles, emphasizing the concepts of building on family strengths and family empowerment.

The majority of the funded sites had extensive prior experience with case management. Caseloads in the first year ranged from 8-30 with an average caseload of 16 families per case manager. Among the 12 projects visited during the first year, three-fourths of the case managers were making home visits at least once every 1-2 weeks. During this first year much of their time was involved in addressing the families basic needs of food, shelter, and housing before they were able to begin to focus on long-term goals such as parent vocational training, education, or parenting skills. Several of the projects are developing teams of two or more staff to share the various case management tasks.

PART III. SUMMARY OF EMERGING ISSUES IN CASE MANAGEMENT

This brief review of the many ways that case management services are being provided in different program areas---welfare reform, long-term care of the elderly, children's mental health, early intervention, and family-focused early childhood programs---has revealed striking differences. While the broad goals of improving coordination, access, and accountability are shared by all these programs, case managers' range of activities and roles, their degree of control over resources, and their caseloads vary enormously.

The fact that case management is attracting such a high degree of interest is a welcome sign that policymakers, administrators, and citizens are now paying serious attention to finding ways of improving the front lines of service delivery. In the ferment and confusion of activity that is now

taking place, certain issues and questions are emerging as needing increased study, experiment, and debate.

Model design

It is clear that no one model of case management will suit the diverse purposes and populations for which it is being used. But it is important to learn more about the effectiveness of particular design components with particular populations. The Office of Technology Assessment is currently conducting a study of the design of the case management component of a federally mandated long-term care program. And we have noted a few other studies that are underway, but clearly more are needed. Some of the more important questions to be addressed are the following:

---Is it more cost effective to target especially needy groups for intensive case management, rather than serve the whole population with less intensive services? If yes, what are the most reliable and inexpensive screening and assessment procedures to determine whether clients belong in the needy group and who should administer them?

---When various service providers are involved with one client/family, what are the most useful mechanisms for assuring a coordinated approach and communication between them? What can be done when clients have several case managers, each of them trying to coordinate services for the one client/family?

---Is family-centered case management a more effective approach for meeting the needs of individual clients than approaches which do not work with family members?

Control and power over resources

Case management services are successful to the degree that case managers have some control over access to services and some influence over the way services are provided. This implies that they will be more effective if changes are made at the administrative and policy levels to create the framework within which coordination between service systems can take place. Some programs and communities are developing these new structures and procedures. We need to learn more about what kinds of policy incentives can be put in place to encourage meaningful interagency agreements and coordination.

Assuring quality and setting standards

In the field of long-term care there has been considerable discussion about how the quality of home-based care services can be assured, especially since these services are much more difficult to supervise than services provided in an institution. Case management is thus seen as one approach to assuring the quality of these services, since it is their responsibility to keep in touch with the client/consumer and find out about whether and how the services are being delivered.

Now that public dollars are increasingly supporting case management services, the question of imposing some kinds of national standards is being raised. Although case management is used as a generic term, each program gives it a distinctive meaning in practice. Proposals to mandate uniform standards for an intervention that is so diverse and by its nature highly individualized are clearly controversial and will need much discussion and debate in the years ahead.

The Office of Technology Assessment study of case management in long-term care will be considering such issues as: What kinds of agencies should perform case management in long-term

care? Should there be mandated requirements or standards for case managers' qualifications and caseload size? Should there be a uniform, federally mandated assessment instrument or should states and agencies be able to develop their own within broad parameters?. Mandating uniform standards in the absence of any empirical data to base them on may be hard to defend. It is possible that best practice guidelines may be considered in their place.

The Department of Health and Human Services is planning to issue mandated standards for case management in the JOBS program in 1993 but it is unclear what points and issues these standards will cover. The APWA is planning to identify case management standards being used in the field.

Training and caseloads

The case manager's job is highly complex, requiring at a minimum a good deal of knowledge specific to the population being served (with respect to needs and services), and to the particular program (eligibility, benefits, procedures), generally requiring some level of interpersonal skills and possibly requiring additional counseling skills. Individuals from all kinds of backgrounds and holding varied positions are now being asked to redefine their jobs or add some case management functions to their existing jobs. Although most programs implementing case management services report that they are providing specialized in-service case management training, to date, there is very little information available nationally about the length of the training, the curriculum content, or the effectiveness of this training. (The APWA is planning to review current training curricula in welfare agencies and will be developing model curricula for state and local human service agencies implementing the Family Support Act.)

It is also important that the training and job expectations be realistically tailored to the size of the trainees caseloads. Case managers with caseloads of over 100, who are spending a third of their time on paperwork, should not be expected to engage in the type of activities that are only appropriate for case managers with caseloads of 50 or less.

Several national organizations are developing and field testing training curricula in family-centered approaches to case management, including the Family Resource Coalition and the National Resource Center on Family Based Services (see below). These curricula include an emphasis on family assessment tools and techniques and development of a family services plan.

Effective training is a key to improved quality and effectiveness of case management services. Public resources need to be devoted to supporting the development of training curricula, the costs of training, and, most importantly, developing incentives for states and agencies to invest time and resources in providing ongoing training to their staff. (Too often federal training dollars go unused.)

Client/family rights and autonomy

Some of the long-term care proposals have emphasized the need to protect clients/consumers' rights but there is little mention in other legislation or the case management literature of the rights of the family or other caregivers, except in the early intervention legislation (P.L. 99-457, Part H) where parents' rights are carefully spelled out and protected.

Some of the questions that need to be addressed are:

---Can family members, as well as clients themselves, challenge the case managers assessment?

---What rights do family members have to accept or refuse services in a surrogate capacity when the primary client is not capable of making decisions autonomously?

---What procedures should be followed when the family disagrees with the case manager or when different family members disagree among themselves?

ORGANIZATIONAL RESOURCES

The following organizations provide information, training, or consultation on various aspects of case management in different program areas.

Case Management Institute of Connecticut Community Care, Inc.

Since 1984, the Institute has been offering the tools necessary to bring together structured training and practical experience in long-term care management of the elderly and disabled, including a strong focus on case management. The Institute offers seminars, training, evaluation, and consultation to individuals and organizations involved in all aspects of case management.

The Institute also publishes the new quarterly *Journal of Case Management*.. The Journal covers a wide range of case management issues in the fields of aging, mental retardation, mental illness, catastrophic care, chronic long-term care, and long-term care insurance.

Contact: Director of Educational Services, Case Management Institute, 719 Middle Street, P.O. Box 2360, Bristol, CT 06010-7442. (203) 589-6226.

Family Resource Coalition

The Family Resource Coalition is in the final stages of a two-year project designed to assist JOBS case managers in Connecticut, Florida, and Illinois as they implement the spirit of the Family Support Act of 1988. The Coalition has worked with these states to assist them in integrating the principles and philosophy of family support into their strategies for moving families towards self-sufficiency. The Coalition held focus groups with JOBS workers, supervisors, and participants, conducted a survey of frontline workers, and is currently completing the development of a comprehensive training program that was fully pilot-tested in Illinois and Connecticut.

The training program (a total of six days of training) includes information on values and attitudes about work, poverty, and welfare; the framework for a family supportive case management model; the process of moving from welfare to work; strategies for family assessment; referral issues; and working with teen parents. The training manual will be made available at a nominal fee to states interested in adopting a family support approach to JOBS case management.

Contact: Karen E. Kelly, Associate Director, The Family Resource Coalition, 200 S. Michigan Ave., Suite 1520, Chicago, IL 60604. (312) 341-0900.

Institute for Family Self-Sufficiency, American Public Welfare Association

The Institute, established with a grant from the Pew Charitable Trusts, is a project of the American Public Welfare Association which focuses on the work of practitioners at the state and local levels to improve welfare systems. The overall mission of the Institute is to reduce poverty among children and their families by promoting self-sufficiency and strengthening family life. To this end, the Institute conducts policy research relevant to implementing the Family Support Act, and provides training and technical assistance for front line workers in the Job Opportunities and Basic Skills (JOBS) program, many of who are designated as case managers.

The Institute also operates a consultant referral service and a clearinghouse for information regarding policies and practices in case management and coordination of services to assist with development and implementation issues.

Contact: APWA, Institute for Family Self-Sufficiency, 810 First Street, NE, Suite 500, Washington, DC 20002. (202) 682-0100.

National Association of Social Workers (NASW)

The National Association of Social Workers is the largest organization of professional social workers in the world. The NASW strongly urges the use of professional social workers in all aspects of the delivery of case management services. NASW views the use of qualified social work professionals in case management as the primary means of ensuring the quality and comprehensiveness of services to clients.

In June 1992 the NASW Board of Directors approved the NASW Standards for Social Work Case Management. The purpose of these standards is to clarify the nature of social work case management as well as the role of the social work case manager. These standards were formulated in full recognition that there is no universally accepted definition of case management, nor is there one definitive model of case management as practiced within the social work profession. Single copies of the standards are available free of charge from the NASW Distribution Center, P.O. Box 431, Annapolis Jct, MD 20701.

Contact: James Brennan, Staff Director, Commission on Health and Mental Health, NASW, 750 First Street, NE, Suite 700, Washington, DC 20002. 1-800-638-8799.

National Center for Children in Poverty

The Center was established in 1989 at the School of Public Health, Columbia University. Its goal is to aims to strengthen programs and policies for young children and their families who live in poverty in the United States. The Center seeks to achieve this goal through interdisciplinary analysis and dissemination of information about public and private initiatives in the areas of early childhood care and education, maternal and child health, and the integration of services for young children and their families.

The Center is a member of the new consortium, the National Center for Service Integration (NCSI), and manages the NCSI Information Clearinghouse. The Clearinghouse collects and disseminates information on service integration issues, strategies, and initiatives. Other NCSI members include: Mathtech (the lead agency); Child and Family Policy Center; National Governors' Association; Policy Studies Associates, Inc.; and Yale Bush Center.

The Center also has a special interest in case management and conducts projects on various aspects. One current project examines states' use of Medicaid funds for case management services affecting children in low-income families. Another studies case management practices in the delivery of social services for low-income families.

Contact: Carole Oshinsky, Coordinator, Information Resources, National Center for Children in Poverty, Columbia University, 154 Haven Avenue, New York, NY 10032. (212) 927-8793.

National Resource Center on Family Based Services

The National Resources Center on Family Based Services (NRC/FBS) provides technical assistance, staff training, research, and information on family based programs and issues. The primary objective of the center's work is the development of high quality family-based services across the United States. Since 1981, the Center has received funding from the DHHS Children's Bureau to serve as as one of the National Resource Centers. The Center provides individualized, on-site, family-based training to direct service workers, supervisors, trainers, and paraprofessionals in human service programs including child welfare, mental health, community action, county extension, and Head Start programs. The Center publishes a quarterly newsletter, the *Prevention Report.*

In response to a growing interest in case management, the Center has implemented a new training program on Family-Based Case Management. The curriculum covers five basic functions: assessment, engaging and motivating the family, case planning, plan implementation, and termination.

Contact: Marcia Allen, NRC/FBS, The University of Iowa School of Social Work, 112 North Hall, Iowa City, Iowa 52242. (319) 335-2200.

Research and Training Center on Family Support and Children's Mental Health, Portland State University

The Research and Training Center, established in 1984 with funds from the National Institute on Disability and Rehabilitation Research (NIDRR) and the National Institute of Mental Health (NIMH), conducts research, consultation, and training of mental health professionals and parents related to improving mental health services, policy implementation, and parent-professional collaboration. The overall goal of the Center is to improve services for families whose children have serious mental, emotional, or behavioral disorders. The Center operates the National Clearinghouse on Family Support and Children's Mental Health and publishes a wide range of resource materials and a quarterly newsletter, *Focal Point.*

The Center's Case Management Project is designed to increase the availability of useful materials regarding services coordination for families whose children have serious emotional disorders. Project activities include the development of working papers on a variety of case management topics. The Center held a national conference on case management for children in March 1992 which was co-sponsored by NIDRR, NIMH, the Mental Health Program for Children and Youth of the Washington Business Group on Health, and the Community Initiative for Children's Mental Health (Annie E. Casey Foundation). An edited book will be developed from conference papers.

Contact: Barbara Freisen, Director, Research and Training Center, Regional Research Institute for Human Services, Portland State University, P.O. Box 751, Portland, OR 97207-0751. (503) 725-4040.

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The Functions and Process of Case Management

Problem Solving Process: Mutual Involvement of Case Manager and Client

Case Recording and Documentation

1.	2.	3.	4.	5.	6.	7.	8.
Client identification and outreach (determination of eligibility)	Individual assessment and diagnosis (determination of level of functioning)	Service planning & resource identification with client & members of service network	Linking client to needed services	Service implementation and coordination (service assessment and trouble shooting)	Monitoring service delivery	Advocacy for and with client in service network	Evaluation of service delivery and case management (may result in continued service* termination or basic follow-up)

Monitoring Process (Service Delivery and Client)

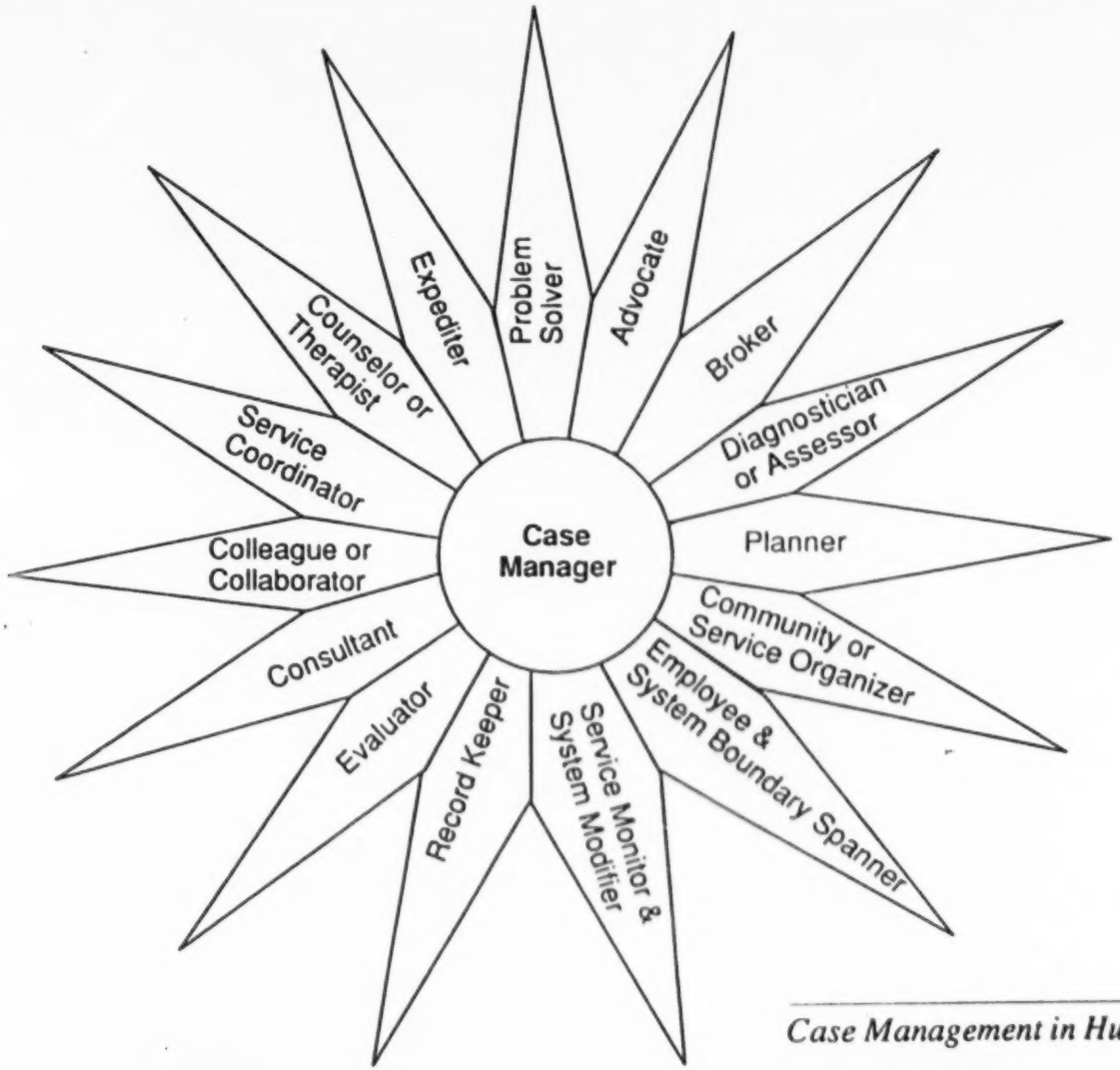
Case Management Process with Service Network

Case Manager Involvement with Case Management Program and Agency

* With same or revised service plan

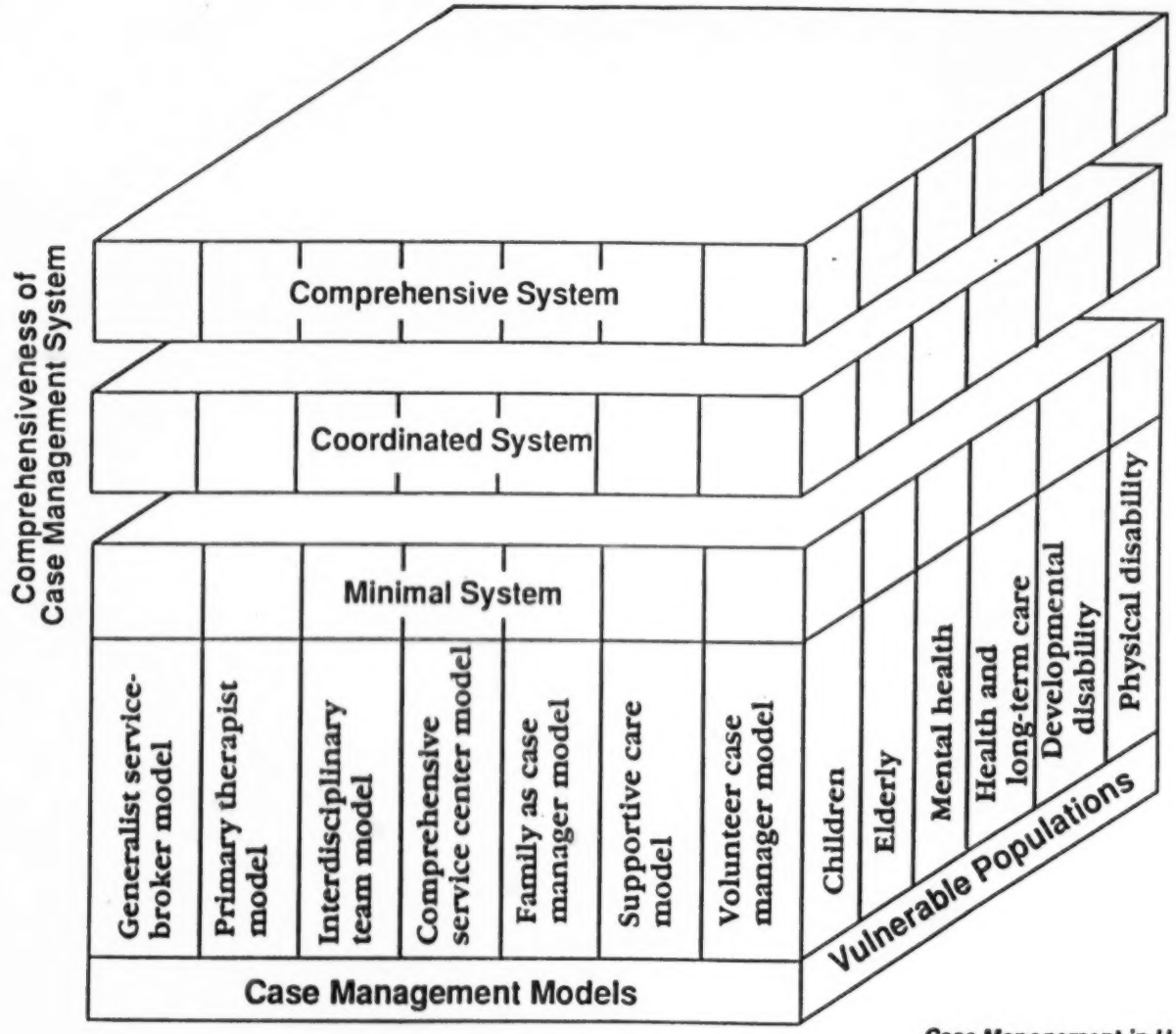
Case Management in Human Service Practice
Weil, Karls, and Associates
Jossey-Bass, 1985

Service Provision Roles for Case Managers—Chart



Case Management in Human Service Practice
Marie Weil, 1985

Case Management System Design Choices



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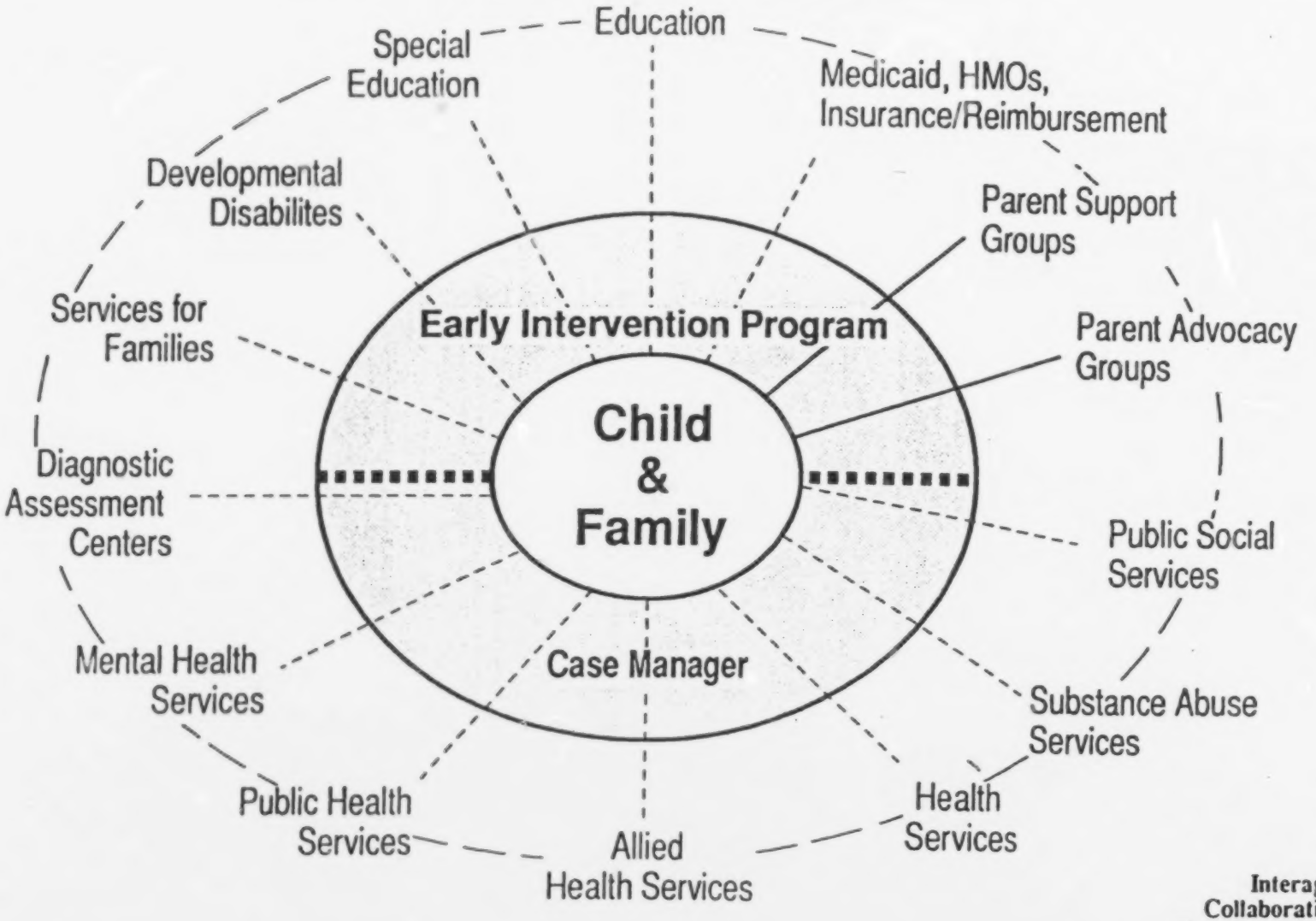
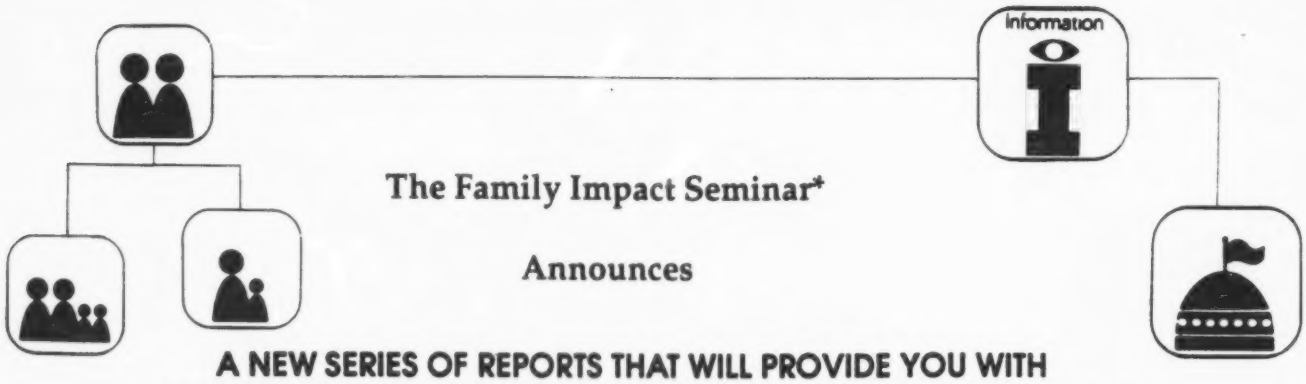
Weil, 1985

Major Service Systems for an Early Intervention Network





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